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MEDICAID AND AFDC FRAUD AND ABUSE CONTROL AND RESTITUTION EFFORTS BY STATES AND LOCALITIES

"BEST PRACTICES" CASE STUDY: NEW JERSEY MEDICAID PROGRAM

November 1976

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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"Best Practices" Case Study

New Jersey Medicaid Program

A Descriptive Review of Exemplary

Program Options

Prepared Under SRS Contract No. SRS-500-75-0004

by

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This report is based on site visits conducted in September 1975 and June 1976. The site visit team consisted of Ms. Jacqueline Cattani and Dr. James Lubalin.

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*On November 1, 1976, the Department of Institutions and Agencies became the Department of Human Services.

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I. OVERVIEW OF NEW JERSEY'S MEDICAID PROGRAM

A. DESCRIPTION OF MEDICAID PROGRAM

New Jersey instituted its Title XIX program later than most states after the passage of the Federal Medical Assistance Program amendments to the Social Security Act. The New Jersey Medical Assistance and Health Services Act was approved in January of 1969 to become effective early in 1970. Program expenditures for 1970 were just over $124 million. Approximately 430,000 persons, or 6 percent of the State's 7,195,000 population, were eligible to receive benefits, and the State experienced a utilization ratio of 3.15 for the first year. In 1975 total program expenditures were $380,190,000 --$193,897,000 Federal and $186,293,000 State funds. The number of eligibles had increased to 580,000, or about 8 percent of the State's population, and the utilization ratio also rose. The average monthly expenditure per recipient was $109.09 in 1975 ($48.67 per eligible).

Provider participation in New Jersey's program has been good. Over 80 percent of the hospitals, physicians and dentists in the State participate in the program. Provider participation by category is as follows:

- Physicians	10,000
- Dentists	7,000
- Laboratories	200
- Pharmacies	1,500
- Hospitals	124
- Skilled Nursing Facilities	230

The scope of benefits provided by the New Jersey Medicaid program is comprehensive, however coverage is limited to the categorically eligible (with minor exceptions involving State aid programs). New Jersey does not cover the medically needy population.

The Department of Institutions and Agencies of the State of New Jersey is the designated single State agency with responsibility for Medicaid. The Division of Medical Assistance and Health Services administers the program. A State Medicaid Commission composed of the Governor, the Commissioner of Institutions and Agencies, the President of the Senate and the Speaker of the General Assembly was constituted to approve and direct the means and method for payment of claims under the Act. An interesting feature of New

Jersey's program is the close involvement of the fiscal intermediaries. Blue Cross of New Jersey and Prudential participated in discussions with the State early in the planning effort. They have continued to play an active role in Medicaid program operations and to have cooperative relationships with the State agency.

B. ADMINISTRATION

The Division of Medical Assistance and Health Services, under New Jersey's Department of Institutions and Agencies (DI & A), administers the Medicaid Program. Figure I depicts the organization of this division, highlighting units with fraud and abuse responsibilities. Within the Division the responsibility for fraud and abuse control lies primarily with the Program Integrity and Utilization Review Administration. The activities of two other organizational units within the Division relate to identification of possible fraud and control of abuse. Under the Medical Care Administration, the office of Complaint Coordination serves as an initial screen for complaints originating at all levels of the program, while the Local Medical Assistance Units (LMAUs) in the field have responsibility for prior authorizations of certain medical services and for initial follow-up on complaints within their jurisdictions. Directly under the Medical Director, the Bureau of Long Term Care is responsible for monitoring quality of care and follow-up of complaints related to nursing homes admitting Medicaid patients.

In addition to fraud and abuse control activities in the Medicaid Division, the fiscal intermediaries, through prepayment claims procedures, and institutional cost audits, have a major impact on fraud and abuse control and deterrence. Both Blue Cross and Prudential have reported significant program savings through reduction or non-payment of claims identified by computer edits and claims review procedures.

The third organizational unit with responsibilities directly related to fraud in the Medicaid program is the State Enforcement Bureau of the Department of Law and Public Safety of the State of New Jersey. The State criminal justice agency has created a Medicaid Fraud Unit (See Figure II) to investigate and prosecute cases of provider fraud in the Medicaid program.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

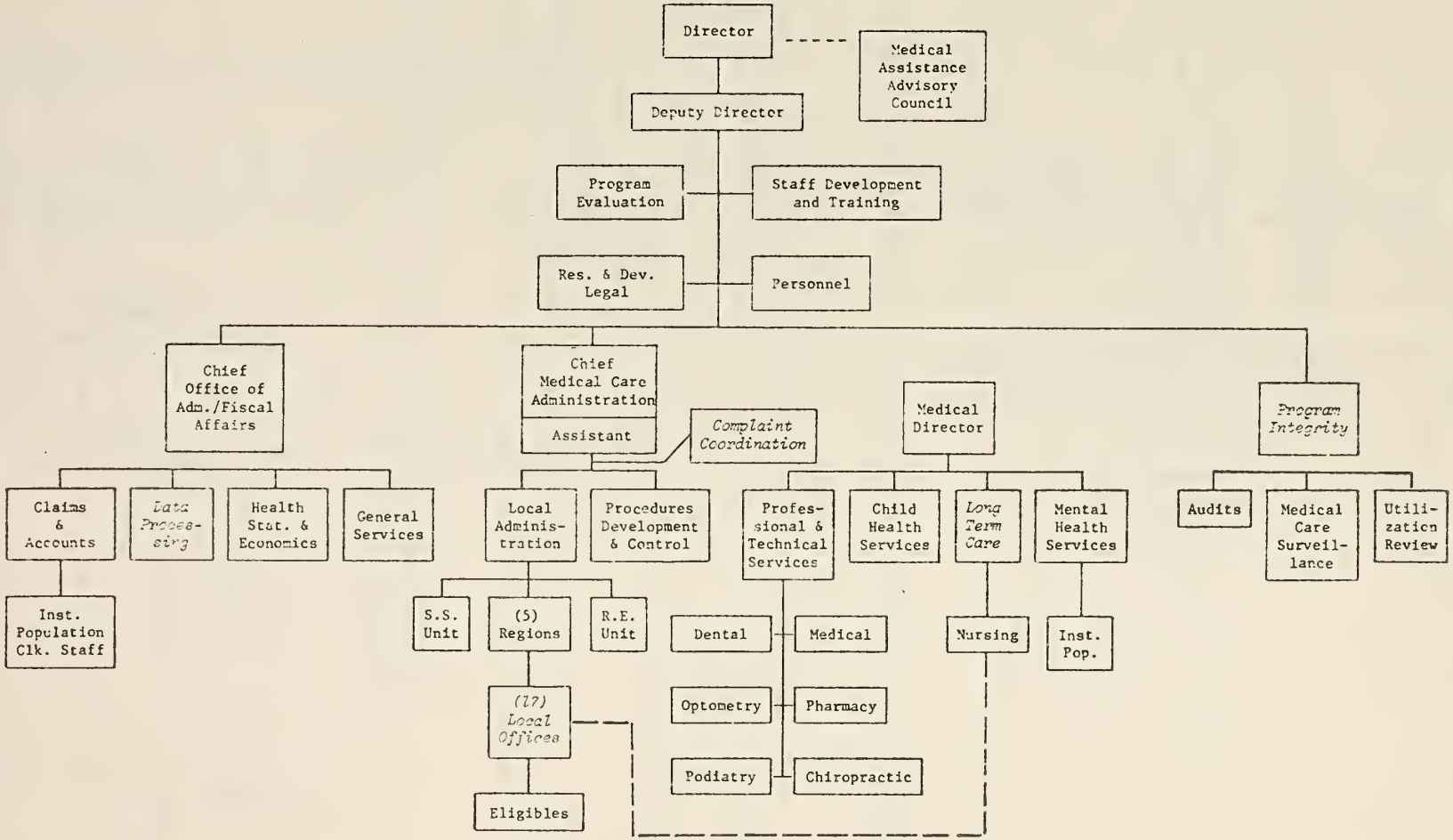


Figure 1: *Organizational Units with Fraud and Abuse Control Responsibility*

DEPARTMENT OF LAW AND PUBLIC SAFETY TABLE OF ORGANIZATION

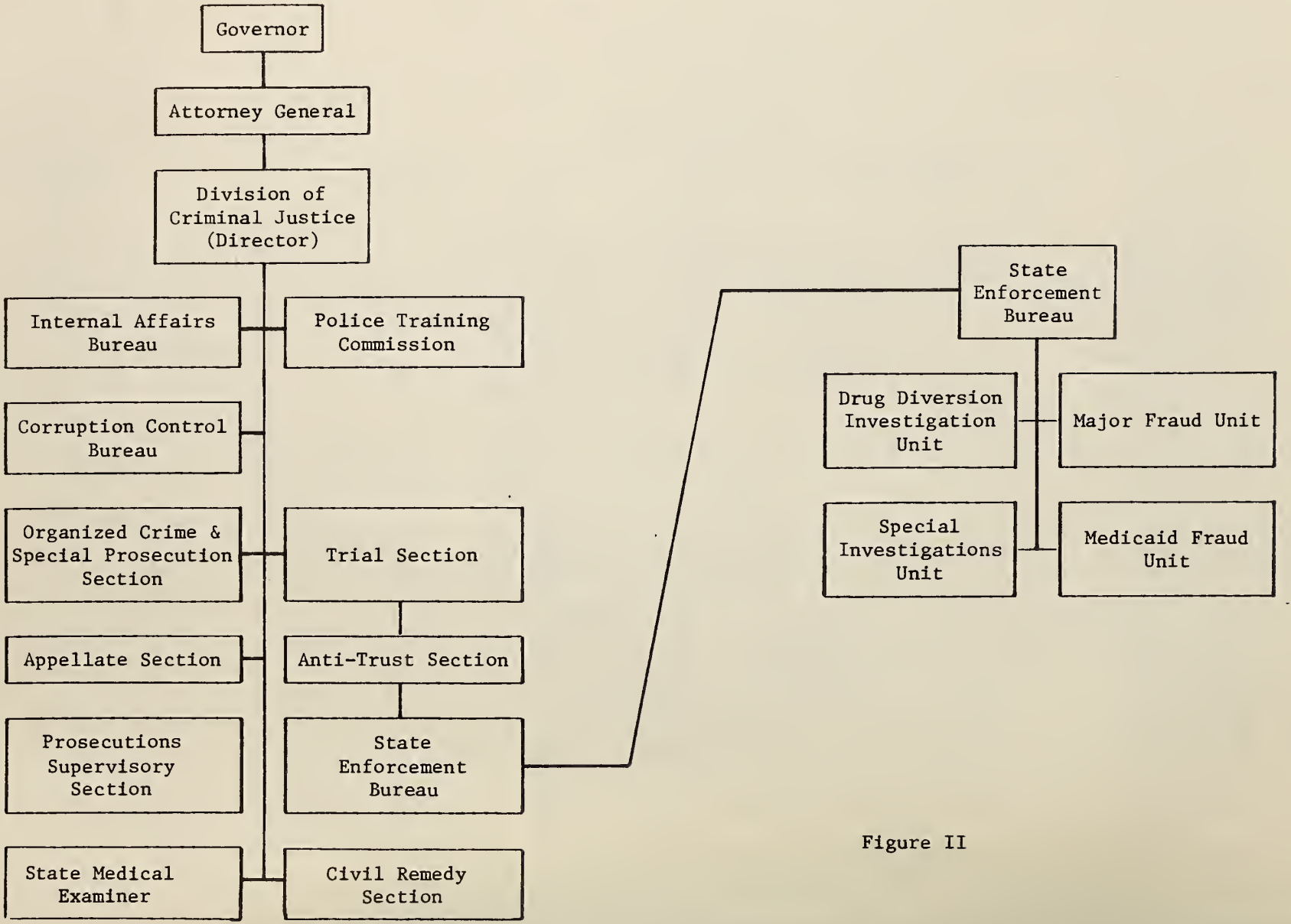


Figure II

The activities of this unit as well as those of the Medical Assistance and Health Services Division and of the fiscal intermediaries will be described in detail in the following sections.

II. PROVIDER FRAUD AND ABUSE CONTROL PROGRAM

A. ADMINISTRATION

Direct responsibility for provider fraud and abuse control in the Medicaid program lies with the Program Integrity and Utilization Review Administration. There are three bureaus within the Program Integrity unit--Bureau of Medical Care Surveillance, Bureau of Audits, and the Bureau of Utilization Review (See Figure III). In addition, activities of the fiscal intermediaries, data processing unit and Medical Care Administration bear directly or indirectly on fraud and abuse control.

1. Program Integrity and Utilization Review Bureau of Medical Care Surveillance

The Bureau of Medical Care Surveillance has had responsibility for Medicaid fraud and abuse surveillance and investigation since December of 1970. Prior to July 1975 it functioned independently under the Director and Deputy Director of the Division of Medical Assistance and Health Services. Since July of 1975 it has functioned as a bureau under the Program Integrity Administration. The Bureau is divided into three units:

- Surveillance Section has primary responsibility for investigation of all non-institutional fraud and abuse.
- Recipient Unit is responsible for investigation of all recipient fraud and abuse.
- Recovery Section has responsibility for recovering Medicaid payments incorrectly or illegally made, including cases where other insurance was in effect, third party liability, Workman's Compensation, out of state claims or if other resources were available to recipients.

The staff of the Surveillance Section and Recipient Unit includes the unit chief, eleven investigators, one part time physician consultant and four clerical personnel. The Recovery Section has eight professional staff members. Professional staff background is a mixture of health care delivery and/or experience in another area of the Medicaid program, law enforcement and financial analysis. It was the general feeling of the Bureau chief that experience in the field of health care was the most desirable in terms of usefulness and training requirements.

Program Integrity and Utilization Review

Organization Chart

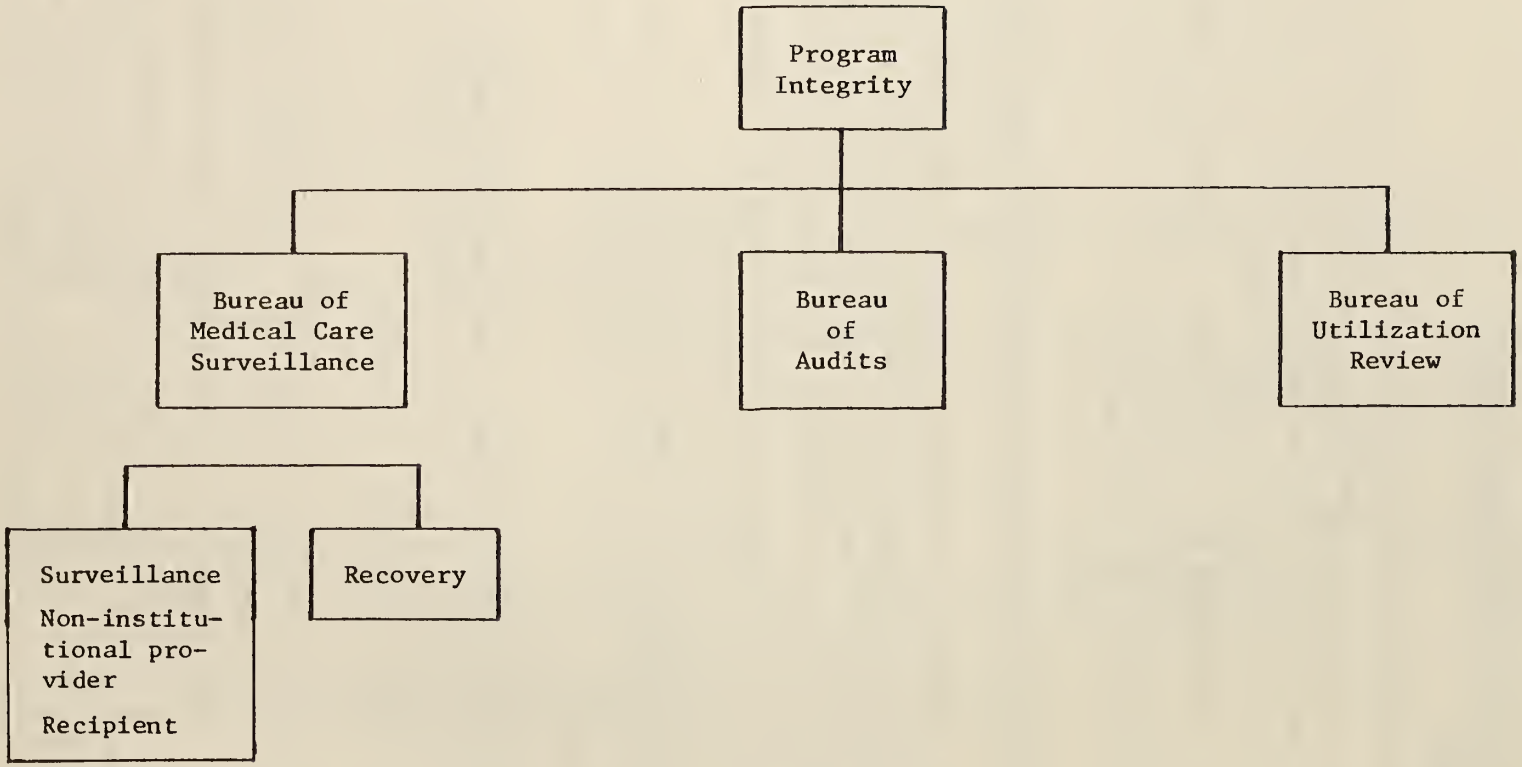


Figure III

Staff members receive approximately three months of on-the-job training before being expected to function independently on a full-time basis.

The main functions of the Bureau of Medical Care Surveillance--Surveillance Section are:

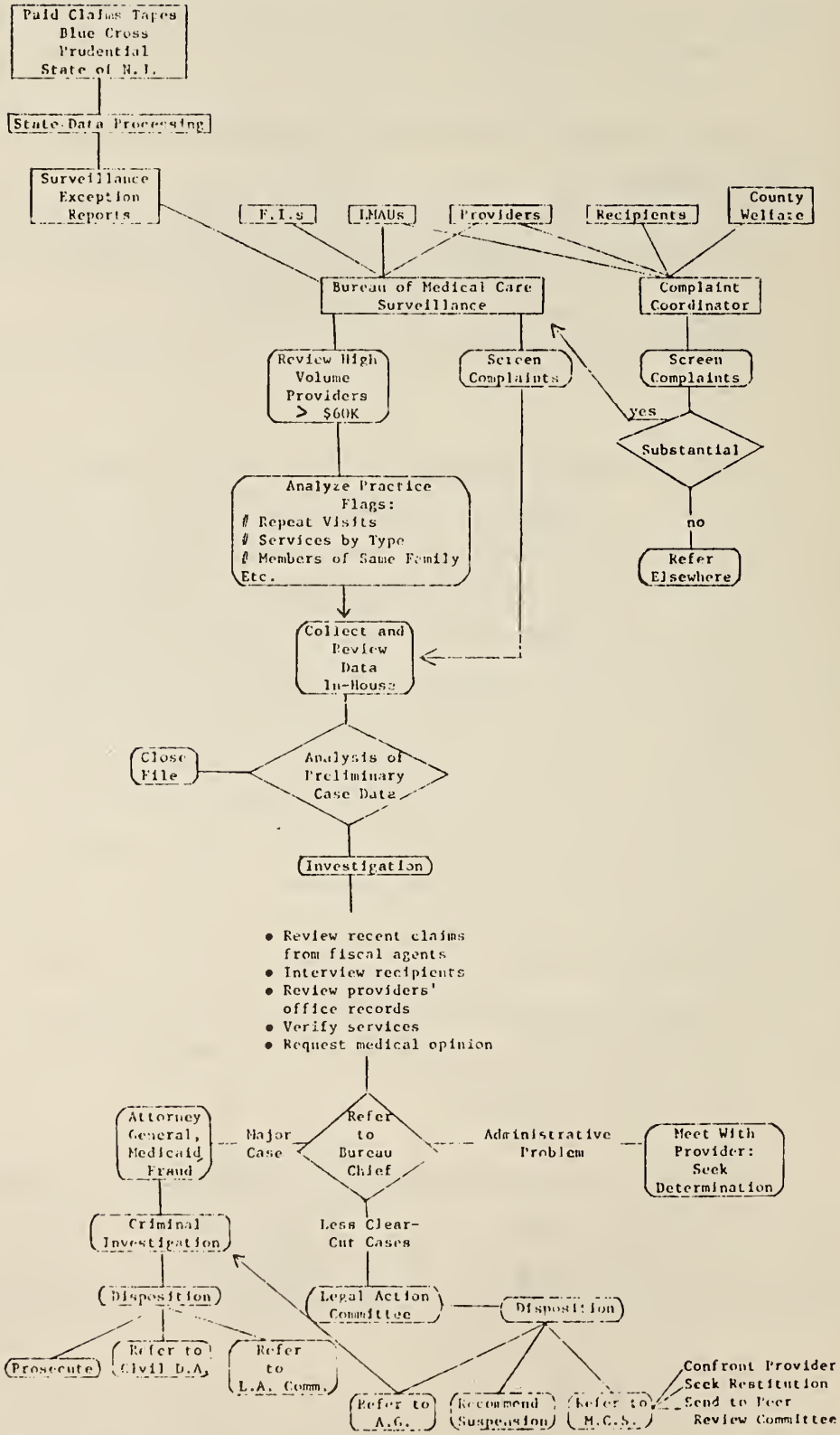
- Analysis of computer generated surveillance exception reports and provider and recipient profiles for questionable patterns, overutilization, misrepresentation, and other abuses.
- Analysis of complaints from external sources.
- Case development leading to restitution, suspension or prosecution.

The case flow diagram (Figure IV) is intended to provide a general idea of the flow of information and decision points in the system. It does not cover every possible decision or resolution, but it provides an overall picture of routine cases. Detailed procedures for case development have been developed and are found in the Bureau of Medical Care Surveillance Handbook (See Appendix A). The Assistant Director for Program Integrity Administration, the Chief of Medical Care Surveillance, the Medical Review Analyst in charge of Recovery and the Deputy Attorney General from the Medicaid Fraud Unit of the State criminal justice agency are the key decision makers in the disposition of cases. The Legal Action Committee resolves those issues where responsibility is less clear-cut. Composed of staff from the State Medicaid Agency and the Attorney General's Office, it assures a close working relationship between the two agencies as well as provides a vehicle for solving problems where responsibility or jurisdiction is in question. The composition and function of the committee will be described in Subsection E. under Outcomes.

In addition to a close working relationship with the Attorney General's Office, the Bureau has regular productive contact with the Welfare Department, the State Health Department, the Fiscal Intermediaries, and with all other organizational units in the Division of Medical Assistance and Health Services.

Figure IV

CASE FLOW DIAGRAM *



*This diagram represents the case flow when the Bureau of Medical Care Surveillance operated independently. It is currently being updated by the Program Integrity Administration to reflect current procedures.

Bureau of Medical Care Surveillance--Recovery Section

The Recovery Section has responsibility for collection of reimbursement from third parties who are liable for medical expenses paid by the Medicaid program. Third party recovery and other insurance and resources account for a major portion of all monies recovered by the Bureau. In fiscal year 1975 a total of $1,333,902 was recovered by the Bureau. Of this figure, $1,249,689 represents recovery from third party and other health insurance sources. Detailed recovery procedures have been developed by the Bureau. The Manual is included in Appendix B of this report.

The Recovery Section handles cases of third party liability, other insurance, out-of-state claims, other resources of recipients and Workman's Compensation. Information relating to claims involving third party liability comes from:

- Monthly reports from Fiscal Intermediaries.
- Notifications from hospitals, physicians or other providers that a request has been made for a copy of bills or medical records of a Medicaid recipient.
- Correspondence from a recipient or his representative requesting information regarding Medicaid expenditures related to an incident.
- Review of recipient profiles and provider paid claims.

Accidents or other traumatic injuries, falls, fractures, etc. are likely cases for review by investigators. The Bureau staff serves notice to appropriate parties stating the legal basis for Medicaid to seek reimbursement. Specific procedures relating to referral to Attorney General, settlements and compromises are found in Appendix B. The major principle involved in compromise and settlements is the requirement of two signatures for approval purposes. All such actions also require the approval and signature of the Assistant Director for Program Integrity Administration. If the case had been referred for civil recovery to the Attorney General's office, the signatures required are those of the Deputy Attorney General and the Medical Care Surveillance Bureau Chief. In cases handled by Bureau Personnel the Bureau Chief and the Division Director must give approval. In cases identified by the Bureau of Claims and Accounts or the Audit Section, the Division Director and the Deputy Attorney General must approve any settlement.

Recovery of third party liability is not always related to fraud and abuse; however, the potential exists if a recipient fails to list such coverage.

Failure of recipients to report other coverage may result in the Medicaid program paying for recipient care which was paid for by other third party payors. When other sources are reported, some providers may attempt to gain payment from both Medicaid and the other party. Recovery of these funds results in significant program savings.

Bureau of Audits

The Bureau of Audit is responsible for regulating institutional providers--specifically nursing homes. Prior to July of 1975 this Bureau was a part of the Bureau of Claims and Accounts under the Office of Administration and Fiscal Affairs (See Figure I). The major functions of the Bureau are:

- o Performance of yearly audits of nursing facilities to assure that charges to Medicaid meet State and Federal regulations, and to reconcile payments with actual costs of reimbursements.
- o Establishment of rates for institutions on a yearly basis.*

The Bureau of Audits covers nursing homes and hospital long term care facilities. Blue Cross of New Jersey performs cost audits of hospitals and submits reports to the Medicaid program.

Staffing patterns and budgets for the Bureau were not available since it had recently been reorganized under the Program Integrity Administration. There is a Bureau Chief, a deputy and 17 field auditors. While the Bureau is primarily concerned with audits and accounting, it does place more emphasis on fraud and abuse investigation than many other state audit agencies. An indication of this emphasis is seen in the reorganization of the Bureau under Program Integrity. If fraud or abuse is suspected, cases are referred to the Attorney General. They are reviewed by the Deputy Assistant Director and Assistant Director for Program Integrity Administration, and based on audit findings, referrals are made to the Legal Action Committee. The Bureau also occasionally receives referrals from the Attorney General and audits are expanded in scope if fraud is suspected. Approved recoveries for 6 months in 1974 totaled over $255,000.

*Effective July 1, 1977, per diem reimbursement rates will be established by the New Jersey Department of Health under contract with the Department of Human Services (formerly the Department of Institutions and Agencies).

Both income and per diem audits are conducted. The goal of the Bureau is to conduct per diem audits biannually and income audits annually. It would be necessary to double the staff in the next two years to be able to meet these goals. Staff is convinced that regular thorough auditing serves as a deterrent to much fraudulent financial manipulation.

Bureau of Utilization Review*

The Bureau of Utilization Review is responsible for reviewing physicians and other providers to identify over-provision of ambulatory services to Medicaid recipients. Inpatient utilization is reviewed by the fiscal intermediaries and review of recipient overutilization is the responsibility of the Bureau of Medical Care Surveillance. The Bureau is staffed essentially by one physician who reviews provider profiles and paid claims tapes for questionable patterns of practice. He may then initiate discussion with the provider or refer the case to peer review. Procedures are more informal than in other Program Integrity units, and statistics were not available since cases usually involve no recovery of funds.

2. Fiscal Intermediaries

Blue Cross of New Jersey, Prudential and the State of New Jersey serve as fiscal agents for the Medicaid Program. Blue Cross processes claims for most inpatient and outpatient hospitals, pharmacies, and home health services. Prudential handles physicians, podiatrists, psychologists, chiropractors, optometrists, dentists, medical suppliers, prosthetist and orthodontist services, some hospitals, independent clinics and laboratories, ambulance services, and home health agencies. The State of New Jersey, Bureau of Claims and Accounts pays for nursing homes and mental hospitals.

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*In February 1977, the Bureau of Utilization Review was terminated. A new Bureau of Utilization Control was established. This Bureau will coordinate all administrative action regarding non-institutional providers and recipients who have undergone initial in-depth review by other bureaus or outside agencies, and to effect settlement of all such cases. The Bureau will also assume the function of coordinating the Division's relationships with all New Jersey PSROs.

Good claims processing systems and good communication with the investigative agency are important for effective control of fraud and abuse. Thorough review of claims prior to payment results in program savings through denial or reduction of improper claims. It also serves as a deterrent to the submission of questionable claims on the part of providers since adjustments tend to delay payment and denials may initiate a more comprehensive review of the provider's practice.

Each of the intermediaries uses a different system of prepayment claims review and postpayment audit. All provide rapid turnaround on provider billings. Blue Cross has implemented a system of tape-to-tape billing which allows for same-day payment for participating providers. Paid claims tapes from each of the intermediaries are turned over to the State's data processing system which merges them and produces the Surveillance Exception Reports to be discussed under Detection. Blue Cross also maintains the recipient eligibility file. Fiscal intermediaries reported a savings of $8,213,588 due to identification of recipients with other insurance, and $2,781,409 through claims review in fiscal year 1975.

3. Bureau of Claims and Accounts--Data Processing

The data processing unit receives all paid claims tapes from the fiscal intermediaries each month. The tapes are merged on the State system and a number of reports are produced for Medical Care Surveillance. Selection criteria are prepared by the Bureau of Medical Care Surveillance at the beginning of each month. Exception Reports which can be requested include:

- Inpatient Hospital,
- Inpatient Diagnosis,
- Outpatient Hospital,
- Outpatient Clinic,
- Physician,
- Podiatrist,
- Optometrist,
- Dentist,
- Drugs,
- Home Health Agency,
- Skilled Nursing Home,
- Special Services, and
- Recipient.

Data processing also produces detailed reports on microfilm for each month. These include provider and recipient profiles listing all services provided or requested for a given time period. An inventory of computer printouts is contained in Appendix C. Examples of these reports are included in Appendix A, the Bureau of Medical Care Surveillance Handbook. All profiles are generated routinely and are made available to Medical Care Surveillance on request.

4. Medical Care Administration

Two organizational units under the Medicaid agency's Medical Care Administration relate indirectly to fraud and abuse.

- Complaint Coordination--receives all incoming complaints from the field (See Figure IV). This office is responsible for screening complaints from recipients, as well as providers. Complaints range from delays in receiving payment to dissatisfaction with fees on the part of providers, to complaints from recipients about facility billings. Most of these complaints are resolved administratively by the Local Medical Assistance Units, the Complaint Coordinator, or are referred to the Health Department or Bureau of Long Term Care. While few result in referral to Medical Care Surveillance, the existence of this office provides a valuable preliminary screen on complaints which otherwise might occupy the time of an investigative unit unnecessarily. A copy of Complaint Procedures is included in Appendix C.
- Local Medical Assistance Units (LMAU)--are responsible for local administration of the Medicaid program in New Jersey. There are 5 regional offices and 16 LMAUs throughout the state. Specific responsibilities of LMAUs include Utilization Review and Periodic Medical Review of Long Term Care facilities (with the Bureau of Long Term Care), prior authorizations of non-emergency medical procedures, issuance of temporary Medicaid cards for Social Security recipients, and liaison with the community. Medical consultants are employed on a full or part-time basis to conduct the reviews and authorizations.

The LMAUs occasionally participate in fraud and abuse investigations, however their role is indirect in nature. Other organizational units, such as the Bureau of Long Term Care under the Office of the Medical Director, also carry out activities with implications for fraud and abuse control, however its major contribution to provider fraud and abuse control is indirect, and it will therefore not be discussed further in this report.

5. Summary of Organizational Responsibilities

There are four major organizations that play important roles in New Jersey's overall provider fraud and abuse control system. In order of direct responsibility and activities they are:

- Program Integrity and Utilization Review
  - Bureau of Medical Care Surveillance,
  - Bureau of Audits, and
  - Bureau of Utilization Review;

- Fiscal Intermediaries;
- Bureau of Claims and Accounts--Medicaid Data Processing;
- Medical Care Administration
  - Office of Complaint Coordinator, and
  - Local Medical Assistance Units.

The State's criminal justice agency will be discussed in subsequent sections of this report.

Table I shows major fraud/abuse control activities and who has primary responsibility for each. While the structure of the overall program is somewhat complex, very little overlap of responsibility exists among organizations.

B. FRAUD AND ABUSE PREVENTION

Fraud and abuse prevention, with the exception of the deterrent factors present in a well structured and publicized surveillance program, is carried out for the most part by other organizations within the Medicaid Agency, the Fiscal Intermediaries, the State Health Department, and the Criminal Justice Agency.

1. Prior Authorization

Prior authorization of medical services serve to strengthen management controls over the Medicaid program. They are required for selected non-emergency procedures such as orthopedic shoes, prosthetic and orthotic services, occupational therapy, speech and hearing therapy, physical therapy, hearing aid accessories and repairs, medical supplies and equipment, certain pharmaceutical services, home health services, dental, ambulance, hospital admissions, long term care, and rehabilitation. Medicaid consultants working out of the Local Medical Assistance Units and Regional Offices review approximately 26,000 requests for prior authorizations each month. Services which have the highest denial rates are orthopedic shoes (18 percent of total requests are denied) and dentistry (17 percent denial rate). Criteria for denial of service include a medical opinion that the patient has reached a point of maintenance and/or does not have the capacity to improve. The LMAU notifies the physician, the fiscal intermediary and the recipient of the approval or denial of a prior authorization.

Table 1

MAJOR FRAUD/ABUSE CONTROL RESPONSIBILITIES IN NEW JERSEY

Activity	Program Integrity*			Fiscal Intermediaries	Data Processing	Medical Care Administration	
	Medical Care Surveillance	Audits	UR			Complaints	LMAUs
Determine Fraud and Abuse Surveillance Policies	X						
Write Manuals for Fraud and Abuse Surveillance	X						
Provide Required Concurrence for Referral to Law Enforcement Officials	X	X[1]					
Decide to Investigate Cases	X						
Perform Desk Audit	X	X					
Perform Field Audit	X	X					
Conduct Recipient Verification of Service	X						X
Identify Third Party Claims	X			X			X
Perform Collection of Third Party Claims	X						
Perform Utilization Review			X	X			X
Conduct Surveillance of:							
- Inpatient Hospitals				X			
- Skilled Nursing Facilities		X					X
- Intermediate Care Facilities		X		X			

Table 1 (continued)

Activity	Program Integrity			Fiscal Intermediaries	Data Processing	Medical Care Administration	
	Medical Care Surveillance	Audits	UR			Complaints	LMAUs
- Physicians	X		X	X			
- Dentists	X		X	X			
- Chiropractors	X			X			
- Podiatrists	X			X			
- Optometrists	X			X			
- Outpatient Hospitals	X			X			
- Clinics	X			X			
- Laboratory and Radiology Facilities	X			X			
- Drugs	X			X			
Conduct Financial Investigation of Institutions		X		X			
Aid and Fire Fraud and Abuse Staff	X						
Operate Claims Processing System				X	X		
Responsible for Insuring Due Process to Individuals	X						
Provide Claims Processing Data Used for Case Findings					X		
Provide Patient and Provider Profiles					X		
Refer Cases to SRS Regional Office	X						

Table 1 (continued)

Activity	Program Integrity			Fiscal Intermediaries	Data Processing	Medical Care Administration	
	Medical Care Surveillance	Audits	UR			Complaints	LMAUs
Negotiate Settlements Before Court	X	X					
Negotiate Settlement After Court	X[2]	X[2]					
Coordinate with Bureau of Health Insurance	X						
Prepare NCSS Reports on Fraud and Abuse	X						
Track Cases Through Law Enforcement Proceedings	X						

1. Reviewed by Division Director
2. In conjunction with civil courts--District Attorney

*All policy and decision making processes, referrals, and coordination with other agencies takes place at or through the Office of Program Integrity Administration.

For the one month period of November 15 through December 14, 1975 case statistics show 27,734 requests of which approximately 2,000 were denied.

Use of prior authorizations for certain services is flexible. The following example was taken from the report on New Jersey's program prepared by Region II DHEW. During a given period prior authorizations were required for vaporizors. The cost effectiveness of this policy was questioned and the need for prior authorization was discontinued. Monitoring showed that the number of claims doubled over a 3 to 4 month period, however the administrative cost of control was greater than the marginal increase in the number of claims.

The Bureau of Local Administration compiles a monthly Statistical Summary Report containing prior authorization activities for each LMAU. The report details the number of prior authorizations by each service pending processing at the beginning of each month, the number of requests received, the number of approvals and denials, and the number pending at the end of the report. A copy of a BLA Monthly Statistical Summary is included in Appendix E.

The use of prior authorizations for non-emergency services not only results in program savings through denial of requests, it also serves as an incentive to providers to consider recommendations more carefully.

2. Rate Setting*

Rate setting is performed by the Bureau of Audits under the Program Integrity Administration and by Blue Cross of New Jersey for inpatient hospitals. Nursing home rates are established by an annual cost study. Desk audits are done and figures are compared with those of the previous year. If any questions arise in the audit, additional information is requested in writing. The Bureau selects facilities which appear to have irregularities (about 10-20 percent) and a thorough field audit is performed.

Field audits include:

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*Effective July 1, 1977 per diem reimbursement rates will be established by the New Jersey Department of Health under contract with the Department of Human Services (formerly DI&A).

Income Audits

- Verification of invoices,
- Verification of patient days,
- Check admissions and discharges,
- Verify physical therapy,
- Audit PIA funds, and
- Check invoices to Medicare or other source.

Per Diem Audit

- Indepth audit of the cost study.

Field audits are performed for the following reasons:

- Accounting irregularities,
- Changes of ownership,
- Recent certification by State Health Department,
- Referrals from Attorney General, and
- Complaints.

Since January 1975 the Attorney General's Office has returned Medicaid fraud indictments on two nursing homes and has active files of investigation being conducted or pending involving 22 homes. Regular auditing is felt by Bureau staff to be a significant deterrent to fraud and abuse.

3. Claims Review

Claims review, including prepayment review and computer edits, are performed by the fiscal intermediaries. Each of the fiscal agents has developed systems which also fulfill their commercial needs.

Prudential

A clerical review of the claim is conducted upon receipt and prior to input into the computer. The review checks for completeness of information and any obvious billing practices or patterns. After this initial screen the claim is entered on the computer where it is subjected to edits and screened for:

- recipient eligibility,
- provider eligibility,
- over 10 home, office of ECF visits per charge line,
- medical care exceeding $500 per claim, and
- third party liability potential.

A post-payment review of high volume providers is also conducted. Types of visits billed are charted and patterns of care are analyzed for abusive

practices. Completed investigations and suspected fraud cases are forwarded to the Bureau of Medical Care Surveillance.

Prudential has indicated the following program savings for fiscal year 1975.

Claims Reduced or Denied in Fiscal Year 1975

Reduced	
High Fee	
Number of Claims	2,309,357
Amount	$29,224,983
Utilization	
Number of Claims	2,209
Amount	$550,650
Denials in Full*	
Number of Claims	70,548
Amount	$4,429,029

* Denials include duplicate bills, ineligible recipients, ineligible services and supplies, program limitations, other insurance, and post-operative care.

- Blue Cross

Blue Cross utilizes two claims processing systems:

- A "hard copy" system uses the claim form submitted by the provider.
- A "Tape to tape" automated system where providers input directly into the computer.

Claims processed under the "hard copy" system are subject to pre- and post-payment edits and audits programmed into the computer. Computer edits include:

- recipient eligibility,
- provider eligibility, and
- length of stay verification.

Post-payment reviews are performed annually on each provider, with a follow-up in three months if discrepancies are encountered. Audits include:

- test of charges,
- verification of identifying information,
- availability of records,
- verification of patient signatures,
- review of treatment plan,
- determination of medical necessity,
- third party liability reffered to Bureau of Medical Care Surveillance,
- verification of charges and diagnostic coding, and
- verification of dates of service and lengths of stay.

Blue Cross has indicated the following program savings in the nine month period of March through November 1975. Fifty-eight audits yielded the following results:

Area of Investigation	Actual Savings
Missing and/or incomplete records	$11,505.27
No-Fault	3,804.36
Coordination of Benefits	1,745.55
Overbillings	304.00
Non-Covered Level of Care	2,037.29
Workmen's Compensation	19,743.99
	Potential Savings
Non-Covered Level of Care	$ 4,531.78

Cost Savings Data

Average Cost per Audit	$78.44
Total Number of Audits	58
Average Recapture per Audit	$340.41
Return-Over-Cost Ratio	4.34

Computer edits for the "tape to tape" system are the same as those for the "hard copy" system. To insure the integrity of claims submitted, a post-payment audit is conducted. Each provider is audited three months after

he begins participating in the tape to tape system. If the findings are routine, providers are audited semi-annually. If discrepancies are found the provider is audited every three months. The results of 40 audits of providers on the tape to tape system produced the following results:

Area of Investigation	Actual Savings
No-fault	$1,489.25
Workmen's Compensation	167.50
Overbillings	1,432.38
Miscellaneous*	7,233.50
Total	$10,322.63

Cost Savings Data	
Average Cost per Audit	$47.74
Total Number of Audits	40
Average Recapture per Audit	$258.07
Return-Over-Cost Ratio	5.41

* Denotes cases where patient's authorized signature was missing.

Monthly reports are submitted by the fiscal intermediaries to the Division of Medical Assistance and Health Services. Additional responsibilities include approval of all new non-institutional providers into the program (Prudential) and maintenance of the recipient eligibility file (Blue Cross).

- State of New Jersey, Administration and Fiscal Services, Bureau of Claims and Accounts

The Bureau of Claims and Accounts serves as the fiscal agent for nursing facilities and mental hospitals. Three pieces of information must be present for claims payment:

1) eligibility verification from Blue Cross files,
2) prior authorization from LMAU, and
3) admission notice to facility.

These controls plus audits serve as preventive measures for fraud and abuse.

4. Provider Certification

Providers must be certified by the Medical Care Administration to participate in the Medicaid program. The provider must file an application form and sign a contract with the Division. Physicians must show evidence of a license, group practices must be in compliance with state corporation and professional association regulations, hospitals must be accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or its equivalent. They must also be inspected and licensed by the state. SNFs and ICFs must submit a cost questionnaire, be licensed by the State Health Department and meed Medicare regulations. The existence of a certification process specific to the Medicaid program has potential for greater control over providers and therefore could serve as a vehicle for provider fraud and abuse control.

5. Patient Signatures on Claims Forms

Claim forms submitted by providers for reimbursement must be signed by the recipient of services. Claims have been denied by the fiscal agent because of missing signatures. There is a potential for abuse here, however, since providers have been alleged to have patients sign a number of forms in advance, and there is little latitude for control over this as it takes place in the physician's office.

practices. Completed investigations and suspected fraud cases are forwarded to the Bureau of Medical Care Surveillance.

Prudential has indicated the following program savings for fiscal year 1975.

Claims Reduced or Denied in Fiscal Year 1975

Reduced	
High Fee	
Number of Claims	2,309,357
Amount	$29,224,983
Utilization	
Number of Claims	2,209
Amount	$550,650
Denials in Full*	
Number of Claims	70,548
Amount	$4,429,029

* Denials include duplicate bills, ineligible recipients, ineligible services and supplies, program limitations, other insurance, and post-operative care.

- Blue Cross

Blue Cross utilizes two claims processing systems:

- A "hard copy" system uses the claim form submitted by the provider.
- A "Tape to tape" automated system where providers input directly into the computer.

Claims processed under the "hard copy" system are subject to pre- and post-payment edits and audits programmed into the computer. Computer edits include:

- recipient eligibility,
- provider eligibility, and
- length of stay verification.

Post-payment reviews are performed annually on each provider, with a follow-up in three months if discrepancies are encountered. Audits include:

- test of charges,
- verification of identifying information,
- availability of records,
- verification of patient signatures,
- review of treatment plan,
- determination of medical necessity,
- third party liability reffered to Bureau of Medical Care Surveillance,
- verification of charges and diagnostic coding, and
- verification of dates of service and lengths of stay.

Blue Cross has indicated the following program savings in the nine month period of March through November 1975. Fifty-eight audits yielded the following results:

Area of Investigation	Actual Savings
Missing and/or incomplete records	$11,505.27
No-Fault	3,804.36
Coordination of Benefits	1,745.55
Overbillings	304.00
Non-Covered Level of Care	2,037.29
Workmen's Compensation	19,743.99
	Potential Savings
Non-Covered Level of Care	$ 4,531.78

Cost Savings Data	
Average Cost per Audit	$78.44
Total Number of Audits	58
Average Recapture per Audit	$340.41
Return-Over-Cost Ratio	4.34

Computer edits for the "tape to tape" system are the same as those for the "hard copy" system. To insure the integrity of claims submitted, a post-payment audit is conducted. Each provider is audited three months after

he begins participating in the tape to tape system. If the findings are routine, providers are audited semi-annually. If discrepancies are found the provider is audited every three months. The results of 40 audits of providers on the tape to tape system produced the following results:

Area of Investigation	Actual Savings
No-fault	$1,489.25
Workmen's Compensation	167.50
Overbillings	1,432.38
Miscellaneous*	7,233.50
Total	$10,322.63

Cost Savings Data

Average Cost per Audit	$47.74
Total Number of Audits	40
Average Recapture per Audit	$258.07
Return-Over-Cost Ratio	5.41

* Denotes cases where patient's authorized signature was missing.

Monthly reports are submitted by the fiscal intermediaries to the Division of Medical Assistance and Health Services. Additional responsibilities include approval of all new non-institutional providers into the program (Prudential) and maintenance of the recipient eligibility file (Blue Cross).

- State of New Jersey, Administration and Fiscal Services, Bureau of Claims and Accounts

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C. FRAUD AND ABUSE DETECTION

Potential cases of fraud or abuse come to the attention of the Program Integrity Administration in a number of ways. The sources of information can be divided into two groups: internal (generated by the surveillance reporting system or through audits) and external (generated from outside sources). Table 2 illustrates the principle sources of information available to the Bureau. The main focus in this section is on the surveillance reporting system. However, as we have pointed out earlier, audit procedures are also important in detecting cases of fraud and abuse.

The primary sources of detection are internal, in the form of Surveillance Exception Reports. Selection criteria most often used for screening providers is high volume of Medicaid claims (>$40,000). Providers with unusual patterns of practice are also candidates for a preliminary investigation.

Surveillance Exception Reports identify those providers and recipients whose use of the Medicaid program exceeds criteria initially specified by the Bureau of Medical Care Surveillance. Detail reports show all claims and adjustments paid to each provider and for each recipient. The detail reports are generated monthly and stored on microfilm. The Exception Reports are requested by submitting selection criteria (numerical values) for the desired reports. A detailed explanation of the use of Surveillance Report selection criteria is found in Appendix A, Section II.

Complaints account for a very small percentage of cases investigated by the Bureau. Most complaints are handled by the Complaint Coordinator and the Local Medical Assistance Units under the Medical Care Administration. New Jersey does not have an Explanation of Benefits program, therefore there is no routine generation of cases by recipient complaints.

A preliminary review of data determines case selection. Surveillance Exception Reports are distributed to investigators assigned for their review. Data applicable to any provider or recipient requiring further investigation is recorded on a Surveillance Information Form.* The forms are placed in a suspense file. The providers identified in the Exception Reports can

*For a more detailed description of the system see Appendix A -- Bureau of Medical Care Surveillance Handbook.

Table 2

SOURCES OF FRAUD/ABUSE DETECTION INFORMATION

Internal

1. Surveillance Exception Reports (computer printouts) and Surveillance Detail Reports (microfilm) by provider type:
   - Inpatient Hospital
   - Inpatient Hospital (Diagnosis)
   - Mental Hospital
   - T.B. Hospital
   - Outpatient Hospital
   - Outpatient Clinic
   - Physician
   - Podiatrist
   - Optometrist
   - Dentist
   - Pharmacy
   - Home Health Agency
   - Nursing Home
   - Optical Appliance
   - Laboratory
   - Ambulance
   - Medical Supply
   - Prosthetic Device

2. Recipient Profiles

3. Provider Profiles (Detail Reports)

4. Prescriber Profiles

5. Audits

External

1. Local Medical Assistance Units

2. Fiscal Intermediaries

3. County Welfare Boards

4. Referrals From Other State Agencies

5. Recipient/Family Friends

6. Providers

be further reviewed by obtaining additional information from the microfilm detail reports.

Information from external sources is recorded on a Complaint Form. Again, information necessary for a preliminary review is obtained from the microfilm detail reports.

Fiscal Intermediaries provide information to the Bureau on a monthly basis in the following categories:

Third Party Liability
Other Health Insurance
Workmen's Compensation
Out-of-State Claims
Denial of Hospital Claims

The purpose of the preliminary review is to collect sufficient information to permit a decision of whether to drop a case or initiate an investigation.

The system provides more than enough cases for investigation by the existing staff. The variety of selection criteria available to generate surveillance reports indicates at least the ability to focus on those problems with the highest potential for success.

D. INVESTIGATION OF FRAUD AND ABUSE

Once the decision is made to open an investigation, the investigator formulates a plan of investigatory action and will record a schedule for proceeding on the Investigations Log. The investigation procedure varies with the type of provider, but the general procedure is as follows:

1. The Bureau Chief will decide to assign one or more of the following personnel to the investigation:
   - staff investigator
   - professional review staff
   - county welfare personnel
   - fiscal agent staff

2. Investigators will utilize any of the following sources of information:

   - surveillance or profile reports
   - fiscal intermediaries
   - county welfare boards
   - local medical assistance units
   - professional review staff
   - general public
   - providers
   - recipients and their families

   Data from the surveillance reports are analyzed for type and frequency of procedures, diagnostic and billing codes indicating overutilization trends, duplicate billing, etc. Recent hand copies of claims can be requested from the intermediaries. Local Medical Assistance Units may be requested to provide additional information.

3. Detailed field investigations are conducted in cases of providers who are suspected of improper utilization of the Medicaid program. The Bureau establishes investigative parameters for specific cases and directs and coordinates field activities of assigned personnel.

4. Field investigations of providers may involve:

   - examination of provider's records including verification of services, analysis of financial records and invoices, etc.
   - interviews with patients to verify services rendered, physical complaints, etc.
   - inspection of facilities

   Specific elements of proof of collusion, falsification of claims, double billing (patient and program), etc., are documented and depending on the nature of the case referred for appropriate action. Table 3 provides additional examples of elements of proof documented in field investigations.

5. A final report is prepared including a detailed history of the case with a summary of the salient facts and recommendations for referral or administrative resolution.

Most investigations undertaken are completed in this manner, however cases may be closed at any step if, in the judgment of the investigators and Bureau Chief, there is insufficent evidence to continue the investigation.

Table 3

ELEMENTS OF PROOF COLLECTED IN INVESTIGATIONS

Type of Proof
Provider payment checks
Recipient verification of services received
Provider documentation of services
Claims histories demonstrative of aberrant practices
Medical records which contradict reimbursement claims
Expert opinion on medical necessity
Documentation of transfer of funds
Documentation of interlocking ownership by groups and individuals who profit from Medicaid reimbursement
Documentation of inclusion of non-allowable expenses
Records of actual costs used to calculate cost-related reimbursement
Billings under another provider's name
Proof of billing for services performed by unlicensed personnel
Proof of billings for non-covered services
Proof of billings for services not performed

E. FRAUD AND ABUSE OUTCOMES

Upon completion of an investigation the case is screened by the Assistant Director for Program Integrity. Cases are presented by the Surveillance Bureau Chief and the analyst who performed the investigation. Based on the merits of the case, the Assistant Director refers the case to either the Division of Criminal Justice, the Legal Action Committee, or the Administrative Action Committee. Four possible dispositions of a case include the following:

- In situations involving apparent fraudulent and irregular activities, the Bureau Chief will forward the case to the Assistant Director for Program Integrity. He will (a) refer the case to the Deputy Attorney General if it appears to be a clear-cut case of fraud, or (b) refer it to the Legal Action Committee for review and recommend disposition.
- In situations involving overutilization or program abuse by the provider the Assistant Director for Program Integrity will decide to (a) refer the case to the Legal Action Committee, or (b) to the Administrative Action Committee.
- In instances where the investigation and subsequent consultation with professional staff indicate that the provider is providing insufficient or poor quality care to patients, the Assistant Director for Program Integrity and the Medical Director may summon the provider to an informal hearing or report the information to the appropriate state licensing agency for corrective action.
- In situations requiring recovery of monies through other insurance or third party liability, the Recovery Section of the Bureau will initiate appropriate actions for recovery.

The majority of cases, with the exception of third party liability, find that the provider "owes" a specified amount of money to the program. Until recently, Bureau staff would meet directly with the provider or his representative to discuss details, conduct additional reviews and to "negotiate" a settlement where it was not a clear-cut case of fraud. The process has become somewhat more structured since the establishment of the Legal Action Committee.

The Legal Action Committee consists of the following regular members:

Director, Division of Medical Assistance and Health Services (DMA & HS)
Assistant Director for Program Integrity Administration
Deputy Assistant Director for Program Integrity Administration
Deputy Director (DMA & HS)
Chief, Audit Section (DMA & HS)

Chief, Bureau of Medical Care Surveillance (DMA & HS)
Deputy Attorney General, Division of Criminal Justice
Deputy Attorney General, Division of Law and Public Safety
Deputy Attorney General, Board of Medical Examiners
Committee Secretary (DMA & HS)
Executive Assistant (DMA & HS)

It allows joint review and decision making between DMA & HS and the Office of the Attorney General, both Civil and Criminal, on appropriate disposition of cases. It can also set maximum and minimum limits within which settlements can be made in recovering monies. On submission of the final report by the Settlement Sub-Committee and on approval of the report by the Director, the case is referred to the Civil Deputy for negotiations with the provider or his representative. In cases where the recovery amount is $5,000 or less, the settlement agreement shall be the final agency action. In cases where the amount is in excess of $5,000 a hearing is convened, recorded, and transcribed to place the terms and conditions of the agreement on record.

If these procedures fail to produce a reconciliation, the provider may request a formal hearing under Chapter 410 of the New Jersey Administrative Procedures Act. A hearing officer presides over the proceedings and both parties may be represented by counsel. Technically rules of evidence need not apply, however, attorneys tend to treat the proceedings as if they pertained.

The informal and formal procedures described here can have three results:

1. Recovery of Money. If the provider agrees to the settlement regarding overpayments at any point in the administrative process he is instructed to repay the money immediately or terms are arranged.* Civil recovery mechanisms are also used as described earlier. Table 4 details recoveries for 1975.

2. Court Action. A case is referred to the judicial system in one of two instances:

*Recently enacted New Jersey Assembly Bill #1455 gives the Division the power to assess interest on recoveries. In addition, this legislation empowers the Division to assess treble damages, false claims, and penalties of $2000 per claim for willful false claims.

Table 4

BUREAU OF MEDICAL CARE SURVEILLANCE

SURVEILLANCE STATISTICS

FISCAL YEAR 1975

Statistics for Fiscal Year 1975

Number of Cases Registered	1,076
Number of Cases Completed	950
Total Monies Recovered This Fiscal Year	$1,333,902.63
Total Monies Recovered Last Fiscal Year	$1,130,214.63

	Cases Registered	Cases Completed	Monies Recovered
Third Party Liability	530	455	$ 649,203.41
Other Insurance/Resources	334	268	600,486.60
Nursing Home	2	5	--
Dentist	20	45	6,326.00
Optometrist/Optician	9	11	650.00
Physician	94	92	45,771.23
Pharmacy/Med. Supps.	31	34	25,508.69
Recipient	36	25	--
Out-of-State	--	1	--
Ind. Clinic/Lab	11	2	--
Podiatrist	1	1	--
Hospital	4	10	5,902.70
Transportation	2	--	--
Other Practitioner	2	1	54.00
	1,076	950	$1,333,902.63

- Lack of resolution through the administrative process. Either the State or the provider may file an action with a court of appeals; or

- Strong evidence of fraud is present. Due to the unique relationship existing between the Criminal Justice Division and the program's Integrity Unit the decision to prosecute is made jointly. While it is true that criminal prosecution involves large amounts of time and resources, both the Medicaid agency and the Attorney General's office feel that the deterrent effect of successful prosecutions is worth actively pursuing.

A unique feature of New Jersey's Criminal Justice Division is the Medicaid Fraud Unit. There are seven investigators covering a current total of 75 active cases. Estimated time to complete a case is as long as one to one-and-a-half years. This produces a large backlog. The unit has had nine convictions since January of 1975. Table 5 lists the State Statutes under which providers have been indicted.

Copies of Medicaid fraud investigation reports are sent to the U.S. Attorney for New Jersey and to the professional licensing boards in the State. Recovery related to criminal prosecutions is handled by the Deputy Attorney General in charge of civil recovery.

3. Suspension and Termination. Providers can be suspended for a definite or indefinite period or permanently terminated from the program by administrative action. During the period from 11/71 through 8/75, 44 providers have been suspended or terminated. Reasons for suspension vary from provision of poor quality medical care to conviction of Medicaid fraud.

Providers who wish to reenter the program after suspension must have a reinstatement hearing. They are watched more closely for a while after reinstatement, but they have generally been observed to not repeat their previous actions.

Table 5

NEW JERSEY STATUTES UNDER WHICH MEDICAID PROVIDERS CAN BE INDICTED

Title 30: 4D-17	Medicaid Statute
2A111-1	False Pretenses (Medicaid supercedes)
2A85-5	Attempt to Obtain Money by False Pretense
2A98-1	Conspiracy
2A98-2	Forgery
2A109-1	Obstruction of Justice (Common Law Offence)
2A85-1	Perjury

III. RECIPIENT FRAUD AND ABUSE CONTROL PROGRAM

The Bureau of Medical Care Surveillance established a Recipient Unit in February of 1976. The purpose of the unit is to identify and report on areas of recipient abuse in the Medicaid program, and to develop procedures for the management of alleged cases of abuse.

Recipient abuse cases fall into the following categories:

- Drug overutilization
- Overutilization of services
- Sale, theft, alteration or loaning of Medicaid card
- Collusion with providers
- Repeated loss of card.

The Unit is concerned primarily with:

1) Overutilization of services;

2) Sale, theft...of a Medicaid card where total amount of services is under $100.00; and

3) Repeated loss of card.

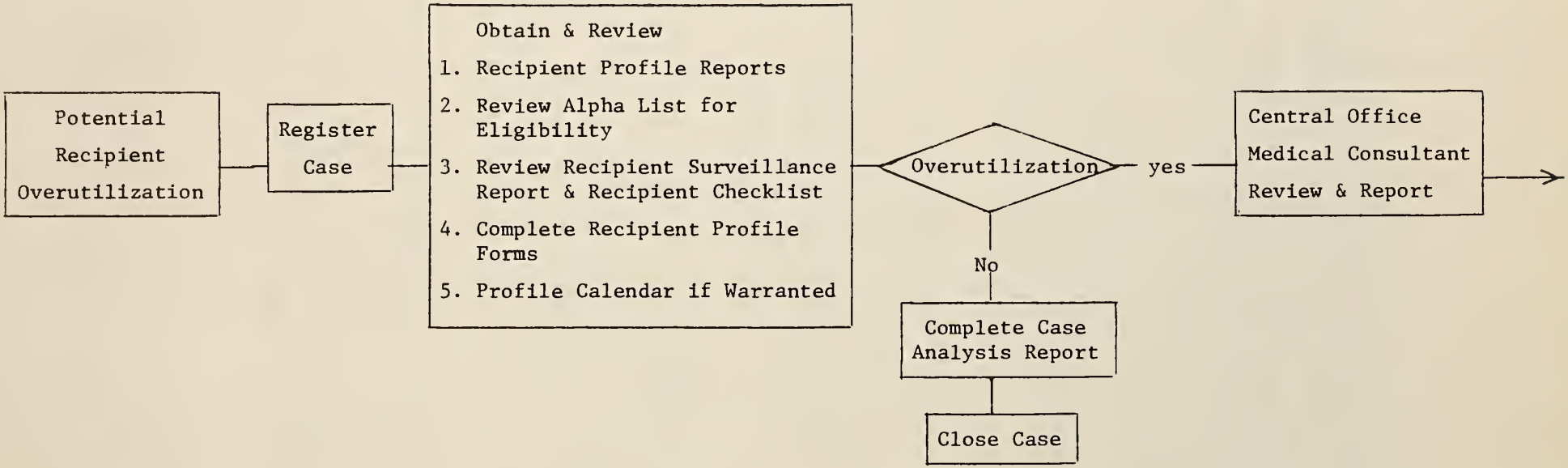
Procedures followed by the Recipient Unit (Figure V) include an in-house review of the recipient's utilization profile and further review by the central office medical consultant. A determination will be made as to the specific nature of the alleged abuse. Given that the case will come under the jurisdiction of the Recipient Unit, a request for provider records would then be initiated.

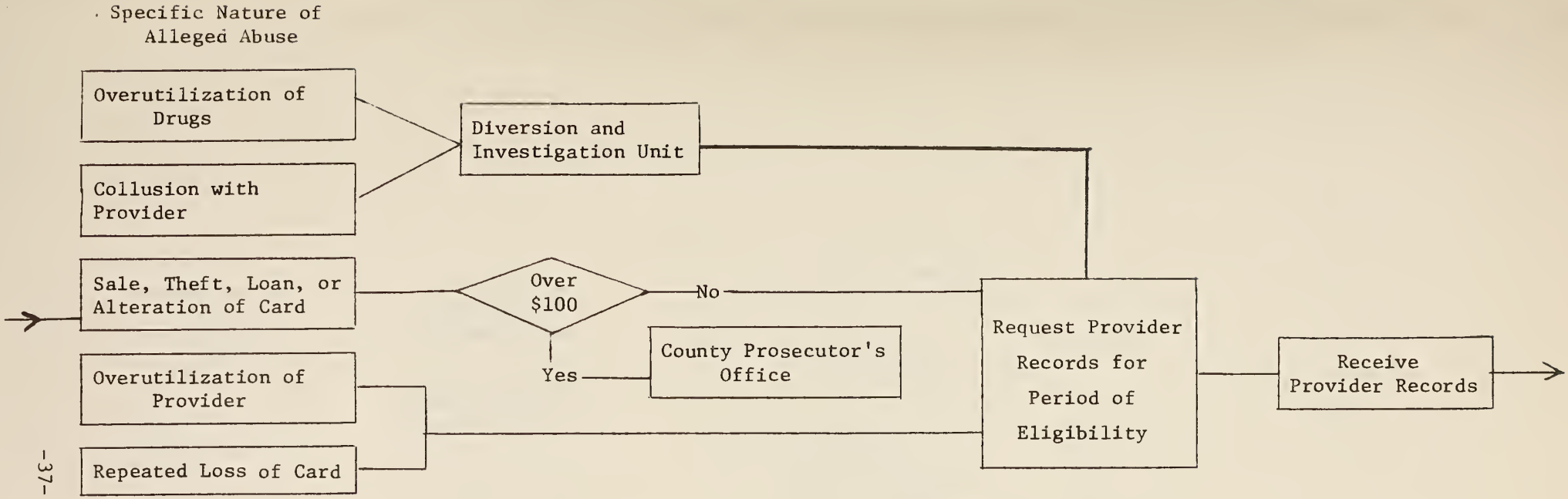
Upon receipt of provider records, the medical consultant again reviews the case. If, in his opinion, further evaluation is needed, contact with the appropriate Local Medical Assistance Unit Administrator is made to arrange a conference. The L.M.A.U. Administrator or his representative then contacts the appropriate welfare board social worker to request her attendance.

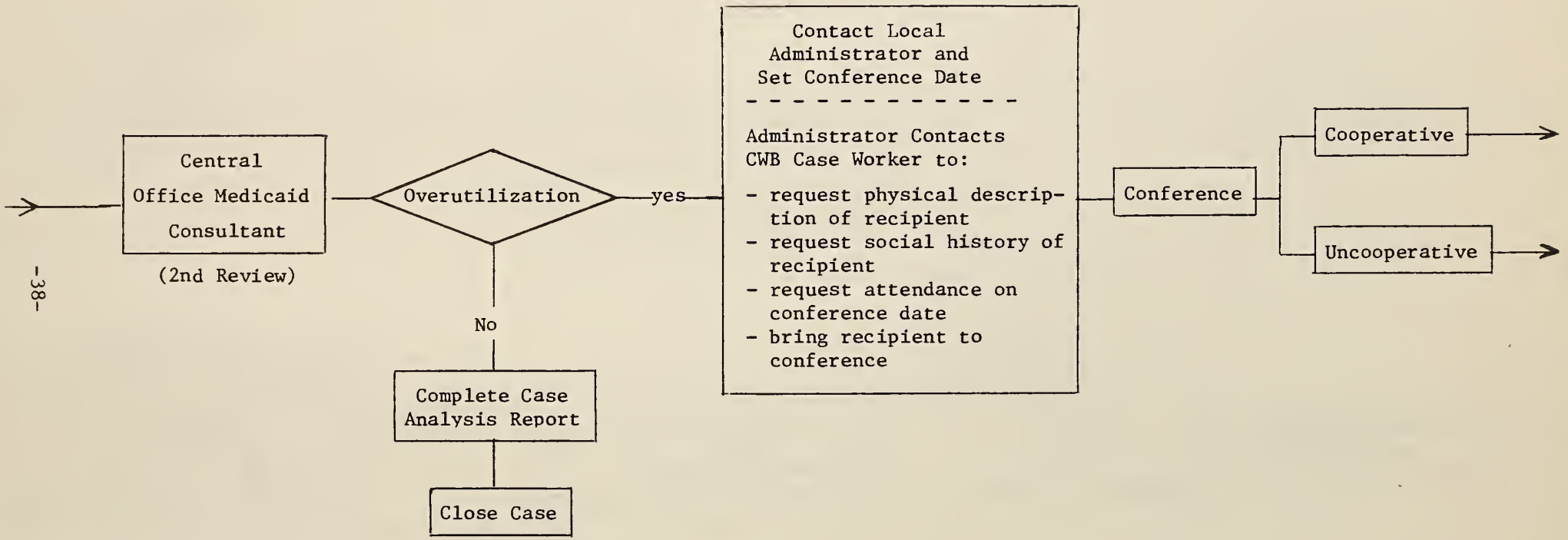
The conference serves to direct the recipient file into a constructive course of action which will result in proper utilization of the Medicaid services. This is to be done voluntarily by the recipient if possible with

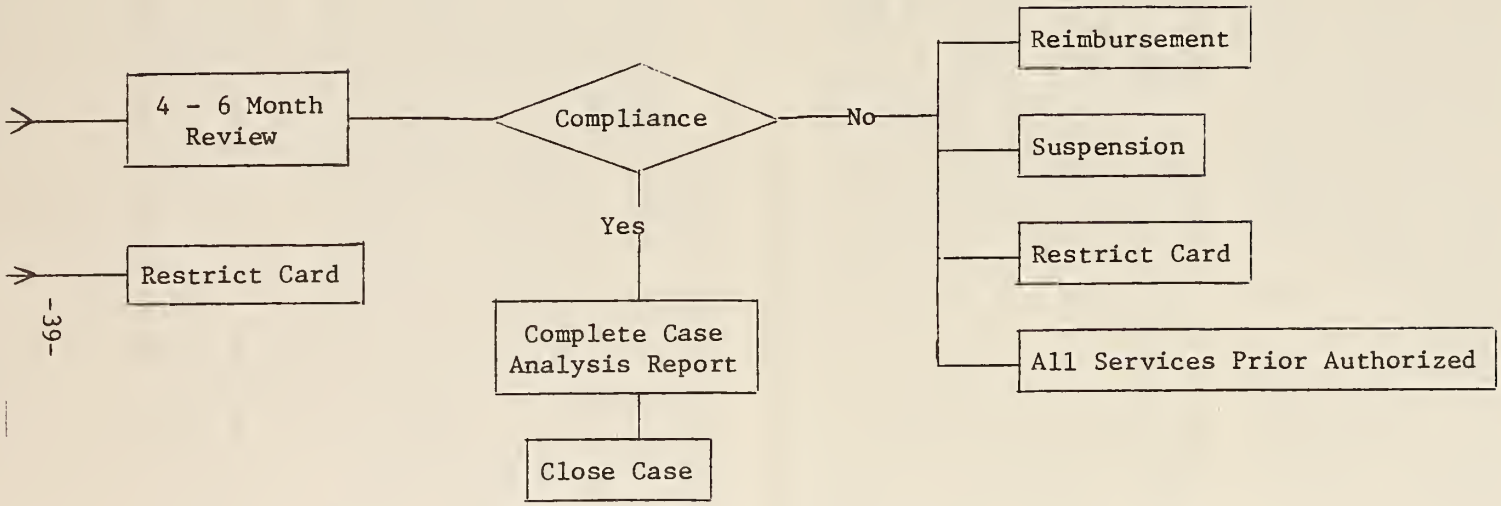
follow-up by the Recipient Unit. If the recipient is uncooperative at the conference or fails to follow the course of action recommended, more stringent measures may be instituted which may include restriction of the Medicaid card to a single provider, prior autyorization for all care, reimbursement, or even suspension. The attached flow chart (Figure V) details the procedures described above.

Figure V. RECIPIENT UNIT PROPOSAL




Specific Nature of Alleged Abuse
Overutilization of Drugs
Collusion with Provider
Sale, Theft, Loan, or Alteration of Card
Overutilization of Provider
Repeated Loss of Card
Diversion and Investigation Unit
Over $100
No
Yes
County Prosecutor's Office
Request Provider Records for Period of Eligibility
Receive Provider Records


Central
Office Medicaid
Consultant
(2nd Review)
Overutilization
yes
No
Contact Local
Administrator and
Set Conference Date
Administrator Contacts
CWB Case Worker to:
- request physical description of recipient
- request social history of recipient
- request attendance on conference date
- bring recipient to conference
Conference
Cooperative
Uncooperative
Complete Case
Analysis Report
Close Case


4 - 6 Month Review
Compliance
No
Reimbursement
Suspension
Restrict Card
All Services Prior Authorized
Yes
Restrict Card
Complete Case Analysis Report
Close Case

IV. AGENCY FRAUD AND ABUSE CONTROL PROGRAM

At the time this report was prepared there were no specific procedures in effect to detect agency fraud and abuse.

V. PROGRAM ASSESSMENT

A. INTRODUCTION

The purpose of the reports being prepared on State Medicaid fraud and abuse control programs is to describe what various States are doing in this area and to identify program characteristics that may have potential for implementation elsewhere. This report is not intended to be an evaluation of New Jersey's program. New Jersey was selected for inclusion in the overall study as an example of a State believed to have a good fraud and abuse control program both in terms of existing systems for detection and investigation of alleged fraud and abuse, and in terms of total program funds recovered. In order to place fraud and abuse control activities in their proper perspective within the New Jersey Medicaid Program it was considered important to collect data on the entire State program and on the environment in which it functions. This was also considered important in the identification and description of characteristics which could be considered "best practices." The report represents an attempt to qualify the "best practices" described in the following section by the circumstances under which they appear to be effective.

B. ASSESSMENT AS REPORTED BY STATE JURISDICTION

The Program Integrity and Utilization Review Administration had only recently been established at the time of our first site visit and all of the problems inherent in the early phases of a reorganization had not yet been resolved. Our second visit saw new procedures in place and working more smoothly. Program Integrity staff was of the opinion that one of the most important features of the New Jersey program was the quality of the working relationships that exist not only within the Division of Medical Assistance and Health Services itself, but also with the Attorney General's Medicaid fraud unit, the fiscal intermediaries, and with other State agencies. Procedures have been designed to minimize conflict and clearly specify responsibility. This is believed to be a key factor in the success of a program with complex inter- and intra-agency relationships.

Particular program strengths noted by the Department of Institutes and Agencies include an active program Integrity Unit with a strong, innovative Administrator and a competent, committed staff. Investigation and recovery procedures are well specified and staff has a balance of health care and investigative experience and training. The computerized surveillance reporting system allows comprehensive review of providers and recipients on the basis of a wide variety of criteria. In addition, intra-agency cooperation and good working relationships with the AG's office, the fiscal agents and other State agencies are believed to facilitate maximum effectiveness in a difficult job.

A few problems were pointed out by Program Integrity staff. Concern was expressed that "errors" on the part of the fiscal intermediaries account for significant expenditures of program funds that are presently not being recovered. Surveillance staff indicated the possibility of documenting the errors in order to indicate the magnitude of the problem. Whether or not that proves feasible the staff believed that a consistent, regular monitoring of the performance of the contractors would provide an incentive for increased accuracy.

Another area of concern mentioned by Medical Care Surveillance staff was the lack of follow-up regarding cases of recipient fraud referred to county prosecutors. The Attorney General's office does not report back to the Bureau of Medical Care Surveillance on the disposition of recipient fraud cases handled by the county district attorneys. While the Medicaid Fraud Unit turns over recipient fraud cases to the counties, there is no formal requirement for reporting back on the disposition of cases. Surveillance staff members believe this to be a critical information gap, and a request has been made that the AG's office initiate reporting procedures to close the gap.

Surveillance staff was of the general opinion that a higher priority should be given to detection and investigation of recipient fraud. The present focus is mainly on provider fraud and abuse with recipient fraud receiving little emphasis. With the development of a recipient unit and the set of procedures described in Section III the Surveillance Section hopes to generate support for these activities within the Program Integrity Division.

VI. BEST PRACTICES

A. INTRODUCTION

The purpose of this report, based on the site visits, is to identify and document those features of New Jersey's fraud and abuse control program that might be useful to other states in the process of developing programs or wishing to improve existing programs. This section presents the practices developed in New Jersey which appear to have potential benefits for other states. We are aware that some of the practices described in the reports are not unique to the state in question. They are, however, included in each individual state report where they are relevant. Best practices identified in these reports will be compiled and analyzed in a final best practices analysis.

B. COMPUTERIZED EXCEPTION REPORTING

New Jersey's computerized surveillance system has been operational since prior to 1970. The state's Data Processing Department merges the paid claims tapes from the fiscal agents and produces exception and detail reports based on selection criteria requested by the Bureau of Medical Care Surveillance. Examples of common selection criteria include providers whose volume of Medicaid claims exceed $40,000 and providers showing unusual patterns of practice. Selection criteria against which use of Medicaid

services by both providers and recipients are measured are specified by BMCS staff. All recipients or providers that exceed the criteria are listed on the exception reports.

An example contained in the Medical Care Surveillance Handbook referenced earlier involves the "In-Patient-Hospital Surveillance Report" (PS01). This report provides data about all in-patient hospitals participating in New Jersey's Medicaid Program regarding discharged patients:

- Total charges;
- Total Medicaid payments;
- Number of Medicaid recipients;
- Average charge per recipient; and
- Average length of stay per recipient.

Criteria are prepared for specific data elements--for example, selection criteria for "total dollar charges for discharged patients" could be specified such that all hospitals with total charges in excess of $10,000 would be listed. A thorough discussion of the use of selection criteria is contained in Appendix A, Section II.

The advantages of utilizing exception reporting are of course the ability to identify those providers and recipients who account for the widest use of services and usually those which account for the highest volume of program funds. This is not to say that high volume providers are guilty of abusing the system, it merely selects a focus for initiating investigations that promise the highest returns.

Since selection criteria values can be easily changed, providers are unable to anticipate the selection values and therefore cannot deliberately maintain their practice "just under" the maximums.

Provider and recipient profiles generated by the computer system are reviewed as a "second step" in the investigation process. Profiles are requested for those providers and recipients who appear on the exception reports and are reviewed for practice patterns or other unusual service or billing activity. Generation and review of profiles allows investigation to focus attention on "problem" areas in reviewing a provider's records.

This activity can save time in field investigations as well as alert the investigator to problems which may not have surfaced in an on-site review.

The computer surveillance system appears to be effective in New Jersey. It provides acceptable criteria for opening new cases and adequate numbers of potential cases are identified for investigation.

C. INVESTIGATION PROCEDURES

Procedures for investigating suspected cases of fraud and abuse have been tailored to maximize the effective utilization of the automated system described above. Carefully structured, well thought out investigative procedures have been designed to assure:

- Effective use of staff;
- Maximum coordination of resources;
- Consistency in collection of required data; and
- Adequate reporting and routing of data.

Well documented, efficiently conducted investigations result in stronger cases and a higher probability of prosecution and/or recovery.

The existence of and adherence to the procedures detailed in the Bureau of Medical Care Surveillance Handbook (Appendix A) also enables new staff members to familiarize themselves with operating procedures and "come up to speed" more rapidly than if well defined tested procedures were absent. We believe that other states could profit from careful review of New Jersey's Surveillance Manual which clearly and concisely presents a step-by-step description of the Bureau of Medical Care Surveillance proceudres. A summary of the procedures is provided in Section II, D.

A general review of files and discussions with field investigators confirmed the fact that the procedures are actually followed. Case files and case statistics were found to be more complete than in many other states.

D. OUTCOMES OF FRAUD AND ABUSE CONTROL ACTIVITIES

1. Administrative Procedures

At some point in the development and investigation of suspected cases of fraud and abuse, a decision must be made regarding case disposition, i.e., prosecution, administrative action, recovery, etc. Decisions are sometimes clear-cut, for example when intent to fraud can be easily established. Often, however, there is some question of whether a case would be more appropriately handled by referral for prosecution or as an administrative action. New Jersey has established a mechanism for making determinations in these cases of questionable outcome. A Legal Action Committee composed of staff from the Division of Medical Assistance and Health Services and from the Attorney General's office (civil and criminal) has been established to rule on these cases.

The Legal Action Committee is composed of the Director and the Deputy Director, the Chiefs of the Audit Section, BMCS and the Bureau of Research and Development of DMA&HS; the Deputy AG, Division of Criminal Justice; the Deputy AG, Division of Law and Public Safety; the Deputy AG, Board of Medical Examiners; and a Committee Secretary and Executive Assistant provided by DMA&HS. The Committee allows joint review and decision making between DMA&HS and the State Law Enforcement Agency. Both BMCS and the Attorney General's office feel that the Committee helps assure the maintenance of a good working relationship between the two organizational entities.

One of the problems raised by the committee, however, is the fact that decisions on cases are often delayed due to the lack of a quorum. Program staff are aware of these problems and have reduced the requirements for quorums, as well as modified the criteria for submission of cases to the LAC in order to avoid a large back-up. Additional responsibilities of the LAC include making recommendations and setting maximum and minimum limits for negotiation of recoveries.

2. Prosecution

New Jersey is one of the only states in which the state Criminal Justice Division has established a separate organizational unit to deal exclusively with Medicaid provider fraud. The Medicaid Fraud Unit falls within the State Enforcement Bureau under the Director of the Division of Criminal Justice (see Section I-B, Figure II). The Unit is under the director of a Deputy District Attorney. The seven assigned investigators are presently covering about 75 active cases and the estimated time necessary to complete a case can be from one year to a year and a half.

The Medicaid Fraud Unit does coordinate its activities with the Program Integrity Division of the Medicaid program, however, in discussing operational aspects of the Unit the Deputy Attorney General stressed a difference in approach for investigations where there is a clear intention to seek prosecution. He felt that investigators and attorneys working out of the Attorney General's office have more flexibility, e.g., being able to work undercover, as well as more authority in terms of being able to subpoena records and testimony. The Unit has had nine convictions from January of 1975 through June of 1976.

The demonstrated commitment to prosecuting providers who attempt to defraud the Medicaid program is believed, both by Program Integrity and the Attorney General's office, to serve as a powerful deterrent. In addition, copies of the Attorney General's investigation reports are sent to the U.S. Attorney for New Jersey and to the professional licensing boards in the state. Recovery of funds related to criminal prosecutions is handled by the Deputy Attorney General in charge of civil recovery.

3. Recovery of Funds

New Jersey has established a Recovery Section within the Program Integrity Division of the Medicaid program. The organizational structure is described in Section II-A. Third-party recovery and other insurance and resources account for well over half of all funds recovered by the Bureau.

Some states have been pursuing third-party and other insurance recovery for some time, while others are just beginning to focus on this area. A main feature of New Jersey's program that may be of interest to other states is a detailed procedural manual, on the order of the Surveillance Handbook, which describes step-by-step recovery procedures, procedures for referrals to the Attorney General and guidelines for settlements and compromises. The manual, discussed earlier, is included as Appendix B and will be of interest to states wishing to set up or improve existing programs. The manual covers:

- Referral of cases to the Attorney General;
- Recovery rules for
  - Medicaid claims
  - Medical assistance to the aged;
- Compromise procedures;
- Settlements;
- Third-party liability;
- Out-of-state claims;
- Other health insurance;
- Other resources;
- Role of the fiscal intermediaries; and
- All forms, correspondence and communications relating to the above.

E. PLACEMENT OF BUREAU OF AUDITS

A feature new to New Jersey's program under the recent reorganization is the placement of the Bureau of Audits under the Program Integrity Division. Previously the Bureau of Audits operated independently of the Bureau of Medical Care Surveillance and was placed organizationally within the fiscal division. Within the previous organizational structure, audits of providers and rate setting were seen as merely accounting functions. Program Integrity staff believe that placement of the Bureau of Audits organizationally within the fraud and abuse control program will have the effect of both encouraging more reporting of questionable practices identified through routine audits to the Assistant Director and subsequently to the Medicaid Investigation Unit, if appropriate, and will serve as an additional deterrent to providers. At the time this report was in preparation, the effectiveness of this change could not yet be determined.

APPENDIX A

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

BUREAU OF MEDICAL CARE SURVEILLANCE HANDBOOK

T A B L E O F C O N T E N T S

INTRODUCTION

Background

Purpose and Organization of Procedures Manual

SECTION I - Information and Procedural Flow

SECTION II - Use of Surveillance Report Selection Criteria

SECTION III - Forms Used in Surveillance System

SECTION IV - Files Maintained in Surveillance System

SECTION V - Surveillance Exception and Detail Reports

I N T R O D U C T I O N

BACKGROUND

A provision of Title XIX of the Social Security Act (Medicaid), requires that "a state plan for medical assistance must provide such methods for, procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care." To satisfy this provision, the New Jersey Department of Institutions and Agencies, Division of Medical Assistance and Health Services has established the Bureau of Medical Care Surveillance for the purpose of identifying and investigating possible abuse of the New Jersey Health Services program.

To support this Bureau, a surveillance computer system has been implemented that will provide exception reporting of those providers and recipients whose use of the Medicaid system may be in conflict with accepted norms. These exception reports will be supported by detail reports that will provide the surveillance personnel with the necessary data for investigation.

PURPOSE AND ORGANIZATION OF PROCEDURES MANUAL

The purposes of this manual are to establish general guidelines for controlling the flow of information through the Bureau of Medical Care Surveillance and to assist the Bureau staff in performing the functions required for effective operation and utilization of the supporting automated system.

Following this introduction, the manual is presented in the following sections:

Section I - Information and Procedural Flow

Section II - Use of Surveillance Report Selection Criteria

Section III - Forms used in Surveillance System

Section IV - Files maintained in Surveillance System

Section V - Surveillance Exception and Detail Reports

SECTION I - OVERALL SYSTEM DESCRIPTION

GENERAL

This section describes the functions which will be performed by the Bureau as a part of the surveillance operation. The main functions are:

- Collection of Data
- Preliminary Review of Data
- Analysis of Preliminary Case Data
- Investigation of Case
- Reporting of Findings and Case Resolution
- Maintenance of Case Statistics

Each of these functions is described below with reference to detailed procedures, specifying the use of selection criteria, forms, files, and reports which are described in subsequent sections of the manual. Exhibit I-1 outlines the flow of information through the Bureau of Medical Care Surveillance. Each operation and function, described in the following sections is indicated in the information flow.

COLLECTION OF DATA

The Bureau of Medical Care Surveillance has several sources of information available for their surveillance of the Medicaid Program. The sources can be divided into two groups -- the information generated by the surveillance reporting system and the information from external sources. Section V describes the information generated by the surveillance reporting system and section II describes the procedures necessary for use of the selection criteria.

Information from external sources can be received at any time. The information may be in the form of a "tip" or a complaint and come from such diverse sources as:

1) local medical assistance units (LMAU)

2) contractors

3) county welfare boards

4) professional consultants

5) recipients/family/friends

6) providers

Of the two groups, the major source of information, especially for reference purposes, is the surveillance report system. Sections III and IV describe the procedures to follow upon receipt of data and information.

PRELIMINARY REVIEW OF DATA

1. Computer sources

Each of the surveillance exception reports will be distributed to the individual(s) responsible for their review. As the investigator reviews each surveillance exception report he will record on the surveillance information form (See Section III) the detail data applicable to any recipient or provider that requires further investigation; i.e., review of the microfilm reports or other sources. These forms will be placed in a suspense file until sufficient information is received to make a decision.

Each of the recipients or providers on the surveillance information form can be further reviewed by obtaining pertinent information from the microfilm detail reports. Information from these reports can be recorded along with the surveillance report information on the surveillance information form.

2. External Sources

Information from external sources will be recorded on the complaint form (described in Section III), which will be filed in the suspense file (described in Section IV) pending preliminary review. If there is sufficient evidence to make a decision to drop the complaint, a letter informing the complainant should be prepared, and the potential case dropped.

Information necessary for a preliminary review can be obtained from the microfilm detail reports, the surveillance reports or other sources.

3. Contractors Sources

Each month the contractors will send the Bureau any information or claims which appear to have potential for surveillance investigation. The information or cases will include the following categories:

a. Third party liability

b. Other health insurance

c. Workmen's compensation

d. Out-of-state claims

e. Denial of hospital claims - fair hearing referrals

4. Preliminary Review

The purpose of a preliminary review is to collect sufficient information to permit a decision to be made whether to drop the case or start an investigation.

The suspense file (see Section IV) is used to store all cases undergoing or awaiting preliminary review.

At the time a decision is made that a case should be investigated, a case analysis summary sheet will be prepared and filed in the case analysis (pending) file.

ANALYSIS OF PRELIMINARY CASE DATA

1. Case Analysis Summary

During the preliminary review process, the investigators have selected those providers and recipients which should be investigated. A case analysis summary sheet is prepared which summarizes the details of the case. The form is described in Section III. In addition a case register and the alphabetical card file are completed. The forms are described in Section IV.

2. Investigation Requirement Work Sheet

The investigators will review all of the preliminary data and case information to determine the action necessary to obtain the requisite information to resolve the case.

An investigations requirements work sheet is prepared and contains the following details which can be used as action guidelines:

a. the questions which require resolution

b. the information necessary for resolution of the questions

c. the investigative steps required to obtain the required information

3. Review by Bureau Chief

The Bureau Chief will review the case and evaluate the investigative action and methods listed by the investigator. His suggestions will be documented on the investigation requirement sheet.

The Bureau Chief may recommend that further information be obtained from such sources as:

a. historical data from the contractors

b. professional opinions from the appropriate medical consulting professionals

4. Final Review Before Full Investigation

A final decision will be made whether to close the case or launch a complete investigation. If the case is dropped at this point, update the case analysis summary and file the case in the completed cases file. (See Section IV for a description of the files.) As well, update the case register and the alphabetical card file to show the current status; i.e., continuing investigation, completed, or dropped.

If a decision is made to continue, proceed with the formal investigation, completing the form, investigations log, as the investigation continues.

INVESTIGATION OF CASE

1. Investigation Log

As soon as the investigator starts the investigation, he will formulate a plan of investigatory action. The investigation requirements work sheet will serve as a guideline for developing a schedule of investigations. This

schedule will be recorded on the investigations log (described in Section III). The log will contain sufficient detail about the investigation to be informative.

2. Investigation may rely on any of the following information sources:

   a. surveillance or profile reports

   b. contractors

   c. county welfare boards

   d. local medical assistance units

   e. professional review staff

   f. general public

   g. providers

   h. recipients and their families

   The Bureau Chief will decide whether to assign a staff investigator to field investigations or to utilize other professional and administrative personnel in the Division or from the contractors (i.e., the professional review staff, the county welfare board, etc.).

3. Request for Information Form

   When the investigator or the Bureau Chief assigns part of an investigation to outside staff or to other external information sources, written instructions of the investigative requirements should be included. These instructions will be typed on a request for information form letter. This form is described in Section III. The instructions should include a description of the case and the type and form of the desired information.

4. Field Investigation

   Detailed field investigations are conducted in cases of providers or recipients who are suspected of improper utilization of the New Jersey Health Services Program. The Bureau will either conduct its own field investigations or utilize in the investigative process other professional and administrative personnel of the Division. The Bureau may also request investigative support from the Contractors, county welfare boards, and other governmental agencies.

The Bureau will establish the investigative parameters in specific cases and will direct and coordinate the field activities of assigned personnel. Field investigations of providers may include an examination of the providers' records, his facilities and interviews with his patients or clients. Field investigations of recipients may include discussions with county welfare board caseworkers, direct contact with recipients or arranging other professional examinations if required.

5. Investigation Report Form (One Per Investigation)

As each investigative action is completed or information returned from a source, the results should be documented on the investigations report form by the investigator. See Section III for a description of the form. The investigator will include any recommendations for further action, as indicated, prompted by analysis of the information. If further action is warranted, the investigations log will be so noted.

6. Final Investigation Report

Upon completions of the investigative actions or review of sufficient information, a final report will be prepared. This report should include the following:

a. detailed history of the case (use references to the previous forms and attach any pertinent documents or information.)

b. a summary of the salient facts with recommendations for appropriate corrective action.

At this point, the Bureau Chief will report the significant findings with recommendations to the Division Director or members of the Utilization Review Committee.

REPORT FINDINGS AND CASE RESOLUTION

1. General

After the investigation is completed and all documentary evidence is evaluated, the Bureau Chief will initiate appropriate corrective action in accordance with Division policy.

2. Guidelines

The Bureau Chief, depending on the type and severity of the case, may forward the case to the Utilization Review Committee, the Division Director or other authorities.

In situations involving apparent fraudulent and irregular activities by providers or recipients, the Bureau Chief will forward the complete case through the Division Director for referral to either the Attorney General, County Prosecutor, or other law enforcement agencies for further review and processing. Examples of such provider situations include collusion with other providers, falsifying claims, consciously charging patients for services with concurrent billing to the Program, etc. Examples of illegal recipient activities include the procurement of drugs, medical supplies, and equipment for illegal use; the loaning of identification cards to non-recipients, etc.

In situations involving overutilization or Program abuse by the provider, the Bureau Chief will initiate correction in a manner consistent with the nature and scope of the case. When appropriate, the Utilization Review Committee or other subcommittee may be utilized to confer with the subject provider and recommend corrective action. In some instances, cases may be referred through the Division Medical Director to the Peer Review Committees of the various health professions.

In instances where the investigation and subsequent consultation with appropriate professional staff, indicate that the provider, though not engaged in fraudulent or abusive practices, is in fact providing an insufficient or poor quality of care to patients, the Bureau Chief, with the concurrence of the Division Director, may summon the provider to the Division's Central Office for an informal hearing and/or report the information to the appropriate State licensing agency for corrective action.

In situations requiring recovery of monies through third party liability or other insurance coverage, etc., the Medical Insurance Recovery Unit of the Bureau will initiate appropriate actions to effect recovery in accordance with established procedures.

3. Case Completion

At the end of the case, after final resolution, the case investigator completes the case analysis summary and all associated documents to form a completed case package. The completed case is filed in the terminated cases section of the Case Analysis File.

The analyst also updates the case statistics summary maintained by the Bureau Chief.

MAINTENANCE OF CASE STATISTICS

The following operating statistics will be maintained for each month.

a. DETAILED OPERATING SUMMARY

Case Classification	No. of Cases	No. of man hours Review/Investigation	Number Solved	Value of those Solved
	(those cases worked on during the month)			
TOTALS	xxx	xx	xx	xx

b. GENERAL OPERATING SUMMARY

Cases continued from last month	xxx
New cases	xx
Cases solved	xx
Cases continued through next month	xxx

SECTION II - USE OF SURVEILLANCE REPORT SELECTION CRITERIA

GENERAL

The automated surveillance support system produces two categories of reports:

- Exception reports, which identify those providers and recipients, whose use of the Medicaid system exceeds criteria initially specified by the Bureau of Medical Care Surveillance.

- Detail reports, retained on microfilm, which show all the claims and adjustments paid to every provider (and for every recipient). These reports are used to obtain supporting detail for use in investigating potential offenders as identified in the exception reports.

The detail reports are generated automatically each month, while the exception reports must be requested by the Bureau. The exception reports are requested by submitting selection criteria forms for the desired reports.

Selection criteria are numerical values against which specified recipient and provider Medicaid activity is to be evaluated. When activity (use of various Medicaid services) is greater or less than the specified numerical values, then all recipients or providers that exceed (or are less than) the criteria will be listed on the exception reports.

For example, the In-Patient Hospital Surveillance Report (PS01) provides data about in-patient hospitals that participate in the Medicaid program. Such data include:

- Total dollar charges for discharged patients
- Medicaid payments for discharged patients
- Number of recipients discharged
- Average charge per discharged recipient
- Average length of stay per discharged recipient

Selection criteria are prepared for specific data elements and specify the value against which that data element is to be evaluated. In this example, selection criteria for the data element "total dollar charges for discharged patients" could be specified to list all hospitals that have total charges in excess of $10,000.

The exception report would then list all such in-patient hospitals and the report would be used as a base from which preliminary investigation could begin. Selection criteria could likewise be prepared for any of the other data elements listed on this, or other exception reports.

Selection criteria are composed of two elements, a selection rule and a selection value.

The selection rule is a code which applies to a specific data element in a specified report. The code indicates whether the value of the data element in the report must be greater than the selection criterion value, equal to the selection criterion value, or less than the selection criterion value specified along with the selection criterion rule. The following codes are used for the three selection criterion rules:

E = equal to the selection criterion value

G = greater than the selection criterion value

L = less than the selection criterion value

For example: code "G" specifies that if the data element value is greater than the selection criertion value, the record is printed on the surveillance report and that data element is marked with an asterisk.

The selection criterion value is an amount or number which refers to a specific data element in a specified surveillance report. The data element in the record is compared with the selection criterion value using the selection criterion rule. For example, suppose the selection value for the "average length of stay" data element in the In-patient Hospital surveillance report is 25 days and the selection rule is "G". Then, if the value of the "average length of stay" in a hospital record was 30 days, the record for that hospital is printed on the Inpatient Hospital Surveillance Report and the "average length of stay" data element is marked with an asterisk.

The selection criteria rule and selection criteria value for any data element may be blank. (If one is blank, the other must be blank). If both values for a data element are blank, that data elment will not cause any provider or recipient to be printed on the exception report. Similarly, if all selection criteria fields for a particular exception report are blank, that exception report will not be printed.

Selection criteria must be prepared at the beginning of each month to request the Surveillance Exception Reports which the Bureau wants to review during that month. The reports which can be requested are the following:

1.	Inpatient Hospital Surveillance Report	(PS01)
2.	Inpatient Diagnosis Surveillance Report	(PS03)
3.	Outpatient Hospital Surveillance Report	(PS04)
4.	Outpatient Clinic Surveillance Report	(PS05)
5.	Physician Surveillance Report	(PS08)
6.	Podiatrist Surveillance Report	(PS09)
7.	Optometrist Surveillance Report	(PS10)
8.	Dentist Surveillance Report	(PS11)
9.	Drugs Surveillance Report	(PS16)
10.	Home Health Agency Surveillance Report	(PS18)
11.	Skilled Nursing Home Surveillance Report	(PS20)
12.	Special Services Surveillance Report	(PS22)
13.	Recipient Surveillance Report	(PS24)

Selection criteria must be specified for each exception report. If a particular exception report is not desired, all selection criteria fields for that report must be blank.

SELECTION CRITERIA FORMS

Three forms are provided for use in specifying the selection criteria. These forms are:

Criteria Selection Date Form
Criteria Selection Form - Surveillance Report Fields
Criteria Selection Form - 25 Most Common Diagnoses

The use of each of these forms is discussed below:

Criteria Selection Date Form (Exhibit II-1)

This form must be completed to accompany the actual Criteria Selection Forms. The data included on this form will be printed on the exception reports to be used for identification purposes. The form is completed as follows:

Type of card (column 1) - The data in the field will always be an "R" to signify that the card will be keypunched as a date card.

Month and year of report data (columns 2-15) - The month and year for which the report data applies is entered in this field.

Date of report run (columns 16-21) - The date on which the computer will produce the reports is entered in this field.

Last day of month of data (columns 22-27) - The last day of the month for which the report data applies will be entered in this field.

Exhibit II-1, coded as a sample, specifies that the report data will be for "September, 1970," the report will be run on October 8, 1970 (10-08-70), and the last day of the month for which the data is applicable is September 30, 1970 (09-30-70).

Criteria Selection Form - Surveillance Report Fields (Exhibit II-2)

This form will be used to request all surveillance exception reports, except for the Inpatient Hospital Diagnosis Surveillance Report (PS03). The form is completed as follows:

Type of card (column 1) - This field will always contain an "S" to signify that the card will be keypunched as a surveillance criteria selection card.

Report No. (columns 2-5) - This field will contain the number of the report which is being requested and for which the selection criteria applies.

Benefit Code (columns 6-7) - This field will contain the benefit code which corresponds to the provider type contained on the report. The valid benefit codes are listed in Exhibit II-4.

Columns 8-11 - This field will be left blank on this form.

Surveillance Report Fields (columns 12-65) - These fields (up to 9) are used to enter the selection criteria. Each field contains 6 positions, the first of which is used to enter the selection rule (E, G, or L) and the remaining five, the selection value. Dependent on the report being requested, each of the 9 fields refers to specified data elements. The detailed procedures for requesting each report, which follow in a subsequent section, identify the specific use of each of the 9 fields.

Exhibit II-2, coding line 1 presents an example. This example requests the preparation of the Inpatient Hospital Surveillance Report (PS01) coded as follows:

Type of Card (column 1) - "S"

Report No. (columns 2-5) - "PS01"

Benefit Code (columns 6-7) - "01," signifying the provider types on this report as being inpatient hospitals

Columns 8-11 - will be blank

Surveillance Report Fields - The Inpatient Hospital Surveillance Report contains up to 9 data elements for which selection criteria can be specified. These fields, and the associated values in the sample line are as follows:

Field 1 - Total charges, discharged recipients

Selection rule - "G"
Selection value - "25,000"

Selection criterion requests a listing of all inpatient hospitals whose total charges for discharged recipients for the month exceed $25,000.

Field 2 - Total ancillary charges, discharged recipient

Selection rule - "G"
Selection value - "15,000"

Selection criterion requests a listing of all inpatient hospitals whose total ancillary charges for discharged recipients for the month exceed $15,000.

Field 3 - Medicaid payments, discharged recipients

Selection rule - "G"
Selection value - "25,000"

Selection criterion requests a listing of all inpatient hospitals whose total Medicaid payments for discharged recipients for the month exceed $25,000.

Field 4 - Number of recipients discharged

Selection rule - "G"
Selection value - "75"

Selection criterion requests a listing of all inpatient hospitals whose total number of discharged recipients exceeds 75.

Fields 5-9 - These fields contain selection criteria for the following data elements:

Average charge per discharged recipient

Average ancillary charge per discharged recipient

Average length of stay per discharged recipient

Percent of discharged recipients whose length of stay exceeds the specified number of AID days

Average excess AID days for recipients discharged with lengths of stay exceeding the number of AID days

Criteria Selection Form - 25 Most Common Diagnoses (Exhibit II-3)

This form will be used to request the Inpatient Hospital Diagnosis Surveillance Report (PS03), which is used to analyze the treatment of the 25 most common diagnoses. The form is completed as follows:

Type of card (column 1) - This field will always contain an "S" to signify that the card will be keypunched as a surveillance criteria selection card.

Report number (columns 2-5) - This field will always contain the surveillance report number, "PS03."

Benefit code (columns 6-7) - This field will always contain the benefit code, "01," signifying an inpatient hospital as the provider.

Diagnosis Code (columns 8-11) - This field will contain the diagnosis code for which the report is being requested. The diagnosis codes for the 25 most common diagnoses are presented in Exhibit II-5.

A separate line is coded for each diagnosis code. If no exceptions are desired for any of the 25 diagnoses codes, all selection criteria for that diagnosis code must be left blank.

Surveillance Report Fields (columns 12-53) - These fields (7 in total) are used to enter the selection criteria for each of the 7 data elements on this report (PS03) for which selection criteria can be specified.

Exhibit II-3, coding line 1, presents an example. This example requests the preparation of the Inpatient Hospital Diagnosis Surveillance Report for the diagnosis, Fibroma Uterine, and is coded as follows:

Type of card (column 1) - "S"

Report No. (columns 2-5) - "PS03"

Benefit Code (columns 6-7) - "01," signifying the provider type as being inpatient hospitals

Diagnosis Code (columns 8-11) - "2180," to signify that the report should list the inpatient hospitals that exceed selection criteria when applied to treatment of only the diagnosis "Fibroma Uterine."

Surveillance Report Fields - The Inpatient Hospital Diagnosis Surveillance Report contains up to 7 data elements for which selection criteria can be specified. These fields and the associated values in the sample line are as follows:

Field 1 - Total charges, discharged recipients

Selection rule - "G"
Selection value - "7500"

Selection criteria requests a listing of all inpatient hospitals whose total charges for the treatment of Fibroma Uterine, during the month, exceed $7,500.

Fields 2-7 - These fields contain selection criteria for the following data elements related to the treatment of Fibroma Uterine only:

Total ancillary charges, discharged recipients

Medicaid payments, discharged recipients

Number of recipients discharged

Average charges per discharged recipient

Average length of stay per discharged recipient

Average excess AID days per discharged recipient

PROCEDURES FOR REQUESTING SURVEILLANCE REPORTS

These procedures are presented in two sections. The first section describes the procedures to be followed in requesting those reports that require the use of Criteria Selection Form-Surveillance Report Fields (Exhibit II-2).

The second section describes the procedures to be followed in requesting the Inpatient Hospital Diagnosis Surveillance Report, which requires use of Criteria Selection Form - Most Common Diagnoses (Exhibit II-3).

Section I - Reports that require use of Criteria Selection Form-Surveillance Report Fields

This section describes the procedures to be followed in requesting each of the following surveillance reports:

- Inpatient Hospital Surveillance Report (PS01)
- Outpatient Hospital Surveillance Report (PS04)
- Outpatient Clinic Surveillance Report (PS05)
- Physicians Surveillance Report (PS08)
- Podiatrist Surveillance Report (PS09)
- Optometrist Surveillance Report (PS10)
- Dentist Surveillance Report (PS11)
- Drug Surveillance Report (PS16)
- Home Health Agency Surveillance Report (PS18)
- Skilled Nursing Home Surveillance Report (PS20)
- Special Services Surveillance Report (PS22)
- Recipient Surveillance Report (PS24)

Inpatient Hospital Surveillance Report (PS01)

1. Code an "S" in column 1
2. Code the report number, "PS01," in columns 2-5
3. Code the benefit code, "01" in columns 6-7
4. Leave blank, columns 8-11
5. Code the selection rules and the selection values for each of the following report fields:

   a. Total Charges - selection rule, column 12
      selection value, columns 13-17

   b. Total ancillary charges - selection rule, column 18
      selection value, column 19-23

   c. Medicaid payments - selection rule, column 24
      selection value, columns 25-29

   d. No. of recipients discharged - selection rule, column 30
      selection value, columns 31-35

   e. Average charge - selection rule, column 36
      selection value, columns 37-41

   f. Average ancillary charge - selection rule, column 42
      selection value, columns 43-47

   g. Average length of stay - selection rule, column 48
      selection value, columns 49-53

   h. Percent of discharged recipients with more than AID days - selection rule, column 54
      selection value, columns 55-59

   i. Average excess AID days - selection rule, column 60
      selection value, column 61-65

Outpatient Hospital Surveillance Report (PS04)

1. Code an "S" in column 1
2. Code the report number, "PS04," in columns 2-5
3. Code the benefit code, "04", in columns 6-7
4. Leave blank, columns 8-11
5. Code the selection rules and selection values for each of the following report fields:
   a. Total charges - selection rule, column 12
      selection value, columns 13-17
   b. Medicaid payments - selection rule, column 18
      selection value, columns 19-23
   c. Number of recipients - selection rule, column 24
      selection value, columns 25-29
   d. Number of visits - selection rule, column 30
      selection value, 31-35
   e. Average charge - selection rule, column 36
      selection value, columns 37-41
   f. Average charge per visit- selection rule, column 42
      selection value, columns 43-47

Outpatient Clinic Surveillance Report (PS05)

1. Code an "S" in column 1
2. Code the report number, "PS05," in columns 2-5
3. Code the benefit code, "05", in columns 6-7
4. Leave blank, columns 8-11
5. Code the selection rules and selection values for each of the following report fields:
   a. Total charges - selection rule, column 12
      selection value, columns 13-17
   b. Medicaid payments - selection rule, column 18
      selection value, columns 19-23
   c. Number of recipients - selection rule, column 24
      selection value, columns 25-29

d. Number of visits - selection rule, column 30
selection value, 31-35

e. Average charge - selection rule, column 36
selection value, columns 37-41

f. Average charge per visit- selection rule, column 42
selection value, columns 43-47

Physicians Surveillance Report (PS08)

1. Code an "S" in column 1

2. Code the report number, "PS08," in columns 2-5

3. Code the benefit code, "06", in columns 6-7

4. Leave blank, columns 8-11

5. Code the selection rules and selection values for each of the following report fields:

a. Total charges - selection rule, column 12
selection value, columns 13-17

b. Medicaid payments - selection rule, column 18
selection value, columns 19-23

c. Number of recipients - selection rule, column 24
selection value, columns 25-29

d. Number of visits - selection rule, column 30
selection value, 31-35

e. Average charge - selection rule, column 36
selection value, columns 37-41

f. Average charge per visit- selection rule, column 42
selection value, columns 43-47

g. Visits per recipient - selection rule, column 48
selection value, columns 49-53

h. Out-of-office visits as a percentage of total visits - selection rule, column 54
selection value, columns 55-59

Podiatrists Surveillance Report (PS09)

1. Code an "S" in column 1
2. Code the report number, "PS09," in columns 2-5
3. Code the benefit code, "07", in columns 6-7
4. Leave blank, columns 8-11
5. Code the selection rules and selection values for each of the following report fields:
   a. Total charges - selection rule, column 12
      selection value, columns 13-17
   b. Medicaid payments - selection rule, column 18
      selection value, columns 19-23
   c. Number of recipients - selection rule, column 24
      selection value, columns 25-29
   d. Number of visits - selection rule, column 30
      selection value, 31-35
   e. Average charge - selection rule, column 36
      selection value, columns 37-41
   f. Average charge per visit- selection rule, column 42
      selection value, columns 43-47
   g. Visits per recipient - selection rule, column 48
      selection value, column 49-53
   h. Out-of-office visits as a percentage of total visits - selection rule, column 54
      selection value, columns 55-59

Optometrist Surveillance Report (PS10)

1. Code an "S" in column 1
2. Code the report number, "PS10," in columns 2-5
3. Code the benefit code, "08", in columns 6-7
4. Leave blank, columns 8-11
5. Code the selection rules and selection values for each of the following report fields:

a. Total charges - selection rule, column 12
selection value, columns 13-17

b. Medicaid payments - selection rule, column 18
selection value, columns 19-23

c. Number of recipients - selection rule, column 24
selection value, columns 25-29

d. Number of visits - selection rule, column 30
selection value, 31-35

e. Average charge - selection rule, column 36
selection value, columns 37-41

f. Average charge per visit- selection rule, column 42
selection value, columns 43-47

g. Visits per recipient - selection rule, column 48
selection value, column 49-53

h. Out-of-office visits as a percentage of total visits - selection rule, column 54
selection value, columns 55-59

Dentist Surveillance Report (PS11)

1. Code an "S" in column 1

2. Code the report number, "PS11," in columns 2-5

3. Code the benefit code, "09", in columns 6-7

4. Leave blank, columns 8-11

5. Code the selection rules and selection values for each of the following report fields:

a. Total charges - selection rule, column 12
selection value, columns 13-17

b. Medicaid payments - selection rule, column 18
selection value, columns 19-23

c. Number of recipients - selection rule, column 24
selection value, columns 25-29

d. Number of visits - selection rule, column 30
selection value, columns 31-35

e. Average charge - selection rule, column 36
selection value, columns 37-41

f. Average charge per visit - selection rule, column 42
selection value, columns 43-47

g. Visits per recipient - selection rule, column 48
selection value, columns 49-53

h. Out-of-office visits as a percentage of total visits -selection rule, column 54
selection value, columns 55-59

Drug Surveillance Report (PS16)

1. Code an "S" in column 1

2. Code the report number, "PS16," in columns 2-5

3. Code the benefit code, "10", in columns 6-7

4. Leave blank, columns 8-11

5. Code the selection rules and selection values for each of the following report fields:

a. Medicaid payments - selection rule, column 12
selection value, columns 13-17

b. Number of recipients - selection rule, column 18
selection value, columns 19-23

c. Number of prescriptions- selection rule, column 24
selection value, columns 25-29

d. Average paid per recipient-selection rule, column 30
selection value, columns 31-35

e. Average paid per prescription-selection rule, column 36
selection value, columns 37-41

f. Prescriptions per recipient - selection rule, column 42
selection value, columns 43-47

g. Refills as a percent of all prescriptions -

selection rule, column 48
selection value, columns 49-53

h. Injectibles as a percent of all prescriptions -

selection rule, column 54
selection value, columns 55-59

i. Prescriptions for recipients in long term care facilities as a percent of all prescriptions -

selection rule, column 60
selection value, columns 61-65

Home Health Agency Surveillance Report (PS18)

1. Code an "S" in column 1

2. Code the report number, "PS18," in columns 2-5

3. Code the benefit code, "11", in columns 6-7

4. Leave blank, columns 8-11

5. Code the selection rules and selection values for each of the following report fields:

   a. Total charges - selection rule, column 12
      selection value, columns 13-17

   b. Medicaid payments - selection rule, column 18
      selection value, columns 19-23

   c. Number of recipients - selection rule, column 24
      selection value, columns 25-29

   d. Number of visits - selection rule, column 30
      selection value, columns 31-35

   e. Average charge - selection rule, column 36
      selection value, columns 37-41

   f. Average charge per visit- selection rule, column 42
      selection value, columns 43-47

   g. Visits per recipient - selection rule, column 48
      selection value, column 49-53

Skilled Nursing Home Surveillance (PS20)

1. Code an "S" in column 1

2. Code the report number "PS20," in columns 2-5

3. Code the benefit code, "12", in columns 6-7

4. Code the selection rules and the selection values for each of the following report fields:

   a. Total charges - selection rule, column 12
      selection value, columns 13-17

   b. Total ancillary charges - selection rule, column 18
      selection value, columns 19-23

   c. Medicaid payments - selection rule, column 24
      selection value, columns 25-29

   d. Number of recipients- selection rule, column 30
      selection value, columns 31-35

   e. Average charge - selection rule, column 36
      selection value, columns 37-41

   f. Average ancillary charges - selection rule, column 42
      selection value, columns 43-47

   g. Average length of stay - selection rule, column 48
      selection value, columns 49-53

   h. Number of recipients greater than 120 days length of stay
      - selection rule, column 54
      selection value, columns 55-59

Special Services Surveillance Report (PS22)

1. Code an "S" in column 1

2. Code the report number, "PS22," in columns 2-5

3. Code the benefit code in columns 6-7 that corresponds to the required report:

   a. Optical appliance report - benefit code 13

   b. Independent laboratory report - benefit code 14

c. Transportation report - benefit code 15

d. Supplies and equipment report - benefit code 16

e. Prosthetic and orthotic appliances - benefit code 17

4. Leave blank, columns 8-11

5. Code the selection rules and values for each of the following report fields (regardless of benefit code):

a. Total charges - selection rule, column 12
selection value, columns 13-17

b. Medicaid payments - selection rule, column 18
selection value, columns 19-23

c. Number of recipients - selection rule, column 24
selection value, columns 25-29

d. Number of claims - selection rule, column 30
selection value, columns 31-35

e. Average charge per recipient - selection rule, column 36
selection value, columns 37-41

f. Average charge per claim - selection rule, column 42
selection value, columns 43-47

Recipient Surveillance Report (PS24)

1. Code an "S" in column 1

2. Code the report number "PS24," in columns 2-5

3. Leave blank columns 6-11 (note that Benefit Code is blank for this report)

4. Code the selection rules and values for each of the following report fields:

a. Inpatient care Medicaid payments-selection rule, column 12
selection value, columns 13-17

b. Practitioners' and outpatient care - no. of visits

selection rule, column 18
selection value, columns 19-23

c. Practitioners' and outpatient care - Medicaid payments
selection rule, column 24
selection value, columns 25-29

d. Nursing Home Medicaid payments-selection rule, column 30
selection value, columns 31-35

e. Drug care - no. of prescriptions-selection rule, column 36
selection value, columns 37-41

f. Drug care-Medicaid payments - selection rule, column 42
selection value, columns 43-47

g. Home Health Medicaid payments-selection rule, column 48
selection value, columns 49-53

h. Other services Medicaid payments-selection rule, column 54
selection value, columns 55-59

i. Total Medicaid payments - selection rule, column 60
selection value, columns 61-65

Section II - Reports that require use of Criteria Selection Form-25 Most Common Diagnoses

The only report that requires the use of this form is the Inpatient Hospital Diagnosis Surveillance Report. The form is completed as follows:

1. Code an "S" in column 1

2. Code the report number "PS03," in columns 2-5

3. Code the benefit code, "01", in columns 6-7

4. Code the diagnosis codes in columns 8-11. (See Exhibit II-5 for a list of the 25 most common diagnoses.)

5. Code the selection rules and selection values for each of the following report fields:

   a. Total charges - selection rule, column 12
   selection value, columns 13-17

   b. Total ancillary charges - selection rule, column 18
   selection value, columns 19-23

c. Medicaid payments - selection rule, column 24
selection value, columns 25-29

d. Number of recipients discharged - selection rule, column 30
selection value, columns 31-35

e. Average charge - selection rule, column 36
selection value, columns 37-41

f. Average length of stay - selection rule, column 42
selection value, columns 43-47

g. Average excess AID days - selection rule, column 48
selection value, columns 49-53

Exhibit II-1

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Bureau of Medical Care Surveillance
Criteria Selection Date Form

	Month and year of Report Data	Date of Report Run	Last Day of Month of Data
R	SEPTEMBER 1970	100870	093170

Exhibit II-2

BUREAU OF MEDICAL CARE SURVEILLANCE

CRITERIA SELECTION FORM

SURVEILLANCE REPORT TITLES

	Value 1	Value 2	Value 3	Value 4	Value 5	Value 6	Value 7	Value 8	Value 9	
01	25000	G 15000	G 25000	G 00075	G 00600	G 00450	09100	02500	G 0001	INPATIENT
02										OUTPATIENT
03										OUTPT. CLINIC
04										HYSICIANS
05										ODIATRISTS
06										PTOMETRISTS
07										DENTISTS
08										DRUGS
09										HOME HEALTH AG.
10										SKL. NURSING HOME
11										OPTICAL APPL.
12										IND. LABORATORY
13										TRANSPORTATION
14										SUPPLIES & EQUIP.
15										PROS. & ORTHO.
16										
17										
18										
19										
20										
21										
22										
23										
24										RECIPIENTS

Punch card form, HSM electric 866137, is available for punching statements from this form

-1B

Exhibit II-3

FEDERAL OR HOSPITAL CARE SURVEILLANCE

CRITERIA SELECTION FORM - 25 MOST COMMON DIAGNOSES

INPATIENT HOSPITAL DIAGNOSES (25 MOST COMMON)

Plan No.	Type	DIAGNOSIS CODE	Value 1	Value 2	Value 3	Value 4	Value 5	Value 6	Value 7	
1 2	3	4 5 6 7 8	9 10 11 12 13 14 15 16 17	18 19 20 21 22 23	24 25 26 27 28 29	30 31 32 33 34 35	36 37 38 39 40 41	42 43 44 45 46 47	48 49 50 51 52 53	54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79
s	0	1 2 1 8	G 0 7 5 0 0	G 0 2 0 0	G 0 7 5 0 0	G 0 0 0 1 0	G 0 0 7 0 0	G 0 0 0 1	G 0 0 0 0 1	F I B R O M Y O M A U T E R I N E
s	0	2 5 0 0								D I A B E T E S M E L L I T U S
s	0	4 1 0 0								I N F A R C T I O N M Y O C A R D I A L A C U T E
s	0	4 1 2 0								C H R O N I C I S C H E M I C H E A R T D I S
s	0	4 5 5 0								H E M O R R O I D S
s	0	4 6 5 0								U P. R E S P I R. I N F E C T. N U L M. S. T.
s	0	4 6 6 0								B R O N C H I T I S A C U T E & S U B A C U
s	0	4 8 5 0								B R O N C H O P N U M O N I A U N S P E C I F I E D
s	0	4 8 6 0								P N E U M O N I A, U N S P E C I F I E D
s	0	5 0 0 0								A D E N O I D A T O P S I I H Y P E R T R O P H Y
s	0	5 3 2 0								D U O D E N U L, U L C E R
s	0	5 3 5 0								D U O D E N I T I S & G A S T R I T I S
s	0	5 4 0 0								A P P E N D I C I T I S, A C U T E
s	0	5 5 0 0								H E R N I A I N G U I N A L W O O B S T R U C
s	0	5 6 1 0								C O L I T I S G A S T R O E N T E R I T I S
s	0	5 7 4 0								C H O L E L I T H I A S I S
s	0	5 9 0 0								I N F E C T I O N S O F K I D N E Y
s	0	5 9 2 0								C A L C U L I O F K I D N E Y & U R E T E R
s	0	6 0 0 0								H Y P E R P L A S I A O F P R O S T A T E
s	0	6 2 0 0								C E R V I X I N F E C T. I N F E C T. D I S E A S E
s	0	6 2 6 0								D I S O R D E R S O F M E N S T R U A T I O N
s	0	6 3 4 0								C O M P L I C. F R O M P R E G N A N C Y C H E R
s	0	6 4 3 0								A B O R T I O N: S P O N T A N E O U S
s	0	7 2 5 0								D I S P L A C. I N T E R V E R T E B R A L D I S K
s	0	8 5 0 0								C O N C U S S I O N

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79

ard card form, 1968 effective 880137, is available for purchase of answers from this form

1C

Exhibit II-4

LIST OF BENEFIT CODES

Benefit Code	Description
01	Inpatient Hospitals
02	Mental Hospitals
03	TB Hospitals
04	Outpatient Hospitals
05	Outpatient Clinics
06	Physicians
07	Podiatrists
08	Optometrists
09	Dentists
10	Pharmacies-Drugs
11	Home Health Services
12	Nursing Homes
13	Optical Appliances
14	Laboratory Services
15	Transportation
16	Medical Supplies
17	Prosthetics and Orthotics

DIAGNOSIS CODES AND DESCRIPTIONS
(25 most common)

Code	Description
2180	Fibroma uterine
2500	Diabetes mellitus
4100	Acute myocardial infarction
4120	Chronic ischemic heart disease
4550	Hemmorroid
4650	Acute upper respiratory
4660	Acute bronchitis and bronchiolitis
4850	Bronchopneumonia, unspecified
4860	Pneumonia, unspecified
5000	Hypertrophy of tonsils and adenoids
5320	Ulcer of duodenum
5350	Gastritis and duoclenitis
5400	Acute Appendicitis
5500	Inguinal hernia
5610	Gastrointeritis and colitis
5740	Cholelithiasis
5900	Kidney infections
5920	Calculus of kidney and ureter
6000	Hyperplasia of prostate
6200	Infective diseases of cervix uteri
6260	Disorders of menstruation

Code	Description
6340	Other complications of pregnancy
6430	Spontaneous abortion
7250	Displacement of intervertebral disc
8500	Concussion

SECTION III - FORMS USED IN SURVEILLANCE SYSTEM

GENERAL

This section of the Procedures Manual describes the forms that will be used by the Bureau of Medical Care Surveillance to record and summarize the investigatory actions on each case. These forms are:

- Case Analysis Summary Sheet
- Investigations Report Sheet
- Investigations Activity Log
- Surveillance Information Form
- Request for Information Form Letter
- Complaint Form

Case Analysis Summary Sheet

The case analysis summary sheet provides a brief summary of the case. It is the first page of a case and should provide the investigator or reviewer with a capsule summary of the details and action taken, if any.

An example of the case analysis summary sheet is provided as Exhibit III-1. The following information is contained on the sheet:

1. Staff assigned and date
2. Case classification and file number
3. A description of the recipient or provider under investigation
4. The source of the initial case information; for example, a complaint or the computer surveillance reports or microfilm reports
5. A case summary, including a brief description of:

    a. suspected abuse or fraud
    b. investigative action
    c. results
    d. resolution of the case

6. Summary information

   a. case disposition (such as terminated, forwarded to law enforcement agency, etc.)
   b. dollar value of recovered funds
   c. recommendations

The "case summary" section of the form can be continued on the second and third pages, if necessary.

The purpose of the case analysis summary is to provide a summary of the case and action, not to provide a detailed description of the case.

Exhibit III-1

Page ____of____

CASE ANALYSIS SUMMARY

Investigator Assigned_____ Date Assigned_____

Classification_____ File Number_____

Provider ( )
NAME Recipient( )_____

ADDRESS_____

Provider ( )
NUMBER Recipient( )_____Specialty_____Age_____Sex_____

PARTICULARS

INFORMATION SOURCE_____

_____

CASE SUMMARY_____

_____

_____

_____

_____

_____

DISPOSITION OF CASE_____

_____

DOLLAR VALUE OF RECOVERED FUNDS_____

_____

RECOMMENDATIONS_____

_____

Report Prepared by_____

Report Reviewed by_____

Investigations Report Sheet

The investigations report sheet will describe in detail the investigative activity and indicate the results and conclusions of the investigation.

The report should include the following information for each investigation. A sample report form is provided as Exhibit III-2.

1. Identification of the recipient or provider who is under investigation.

2. The date, place and people involved in the investigation.

3. A description of the reasons and objectives of the investigation.

4. A description of the results of the investigation - information obtained, conclusions drawn, implications, and recommendations for further action.

If a case is comparatively short, the reports can be replaced by the Investigations Activity Log where appropriate comments have been added.

The report sheets will provide an accurate and complete description of all the investigative activity undertaken during the course of the investigation. They should be presented in chronological order by date so that a reviewer, by reading each report, will have the current status.

Investigations Activity Log

The activity log (Exhibit III-3) provides a chronological record by date of all the activities conducted in the case investigation. Each activity which an investigator starts must be recorded in the activity log. The log will include the following information:

1. Identification of the recipient or provider who is under investigation.

2. The date and place of investigation.

3. A brief description of the investigation.

INVESTIGATION REPORT

CASE FILE NUMBER _____

NAME: Provider ( ) Recipient ( ) _____

FINDINGS AND RECOMMENDATIONS

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

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_____

_____

_____

Signature

Exhibit III-3

INVESTIGATION ACTIVITY LOG

CASE FILE NUMBER _____

NAME: Provider ( ) Recipient ( ) _____

Investigation Action Date Month, Day, Year	Description of Investigation Activity

_____

Signature

4. References to future dates when some action or event is to take place. For example, the investigator may ask a witness to search for some information, and send it to him in two weeks. The investigator notes that the recipient of information is due in two weeks.

The purpose of the log is to maintain a control and record of all investigations. Control is maintained by summarizing the activity and noting the dates when information which had been requested is due.

The backup document for this log is the investigation report, a summary of the action and results of each investigation. Where a case is relatively short, this log may be substituted for the investigations report.

SURVEILLANCE INFORMATION FORM

The surveillance information form (Exhibit III-4) is used to record data from either the surveillance reports or the microfilm detail reports.

As the Bureau staff reviews the surveillance reports, they will record any information which may indicate abuse, overutilization, etc. of the Medicaid program. When the staff has finished with the surveillance reports, further detailed information can be recorded from the microfilm detail reports.

The following information will be recorded:

1. Name, date and page of the report and the information reviewed and recorded

2. All of the pertinent information such as:

   a. name of the recipient or provider

   b. description of the medical abuse or overutilization with the dollar amounts involved. (From the surveillance exception report.)

   c. description of the medical case history involving previous treatments, drugs, etc. and the individual(s) and total dollar amounts involved. (From the microfilm detail report.)

   d. other historical information which may lead to the implication of other recipients or providers

SURVEILLANCE INFORMATION

Report Name & Date	Prov./Recip Number	Prov./Recip Name	Description of Data Fields In Excess of Selection Criteria Values

Where information will be used for a case investigation, a xerox of the surveillance or detail report must be attached to the form.

REQUEST FOR INFORMATION FORM LETTER

This form letter (Exhibit III-5) is used to request information from outside sources such as the contractors, the county welfare board, the local medical assistance units, etc.

The following information should be detailed on the form:

1. Description of the organization being asked to furnish the information (name, etc.)

2. Description of the case in question

3. Description of the desired information

4. An indication of when the Bureau needs the information

5. Special instructions.

Where cases can be classified into certain groups, form letters should be used for requesting information which is common to a particular classification of cases.

COMPLAINT FORM

This form (Exhibit III-6) is used to record and describe complaints which suggest a potential abuse of the Medicaid system.

The information should be as complete as possible and include at least the following information:

1. A basic statement of the problem

2. A summary of the circumstances of the case

3. The dates of occurrence of the problems

4. The recipients or providers involved

5. The estimated amounts of money involved, if any

Exhibit III-5

REQUEST FOR INFORMATION

TO: NAME _____

ADDRESS _____

_____

ATTACHMENTS:

_____

_____

_____

DESCRIPTION OF DESIRED INFORMATION AND/OR FIELD INVESTIGATION

_____

_____

_____

_____

_____

SUGGESTIONS:

_____

_____

_____

RETURN TO:

_____

_____

_____

_____

Sincerely yours,
Bureau of Medical Care Surveillance

6. The type of case - e.g., third party liability

7. Suggestions for possible investigation and resolution

8. Attach any pertinent documents.

If a complaint from a recipient or provider is contained in a letter, then the salient information should be copied on the complaint form and the letter attached to the form.

Exhibit III-6

COMPLAINT REVIEW FORM

Provider ( )
NAME: Recipient( ) _____ Number _____

ADDRESS _____

_____

SOURCE AND DESCRIPTION OF COMPLAINT:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

RECOMMENDATIONS:

_____

_____

_____

_____

_____

_____

_____

SECTION IV - FILES MAINTAINED IN SURVEILLANCE SYSTEM

GENERAL

This section of the Procedures Manual describes the files that are maintained within the Bureau of Medical Care Surveillance to support the surveillance system. These files are:

- Surveillance Detail Reports File
- Surveillance Exception Reports File
- Case Analysis File
- Recoveries of Money File
- Case Register
- Alphabetical Card File

The contents of each file are described as well as pertinent procedures relating to maintenance of the files.

Surveillance Detail Reports File

All surveillance detail reports, which the Bureau receives, have been microfilmed and are to be maintained in this file. There will be one set of microfilmed reports for each month of the processing year.

At year-end, the monthly reports will be replaced by one consolidated set of detail reports on microfilm for the total year. These are to be labeled and filed in the same manner as the monthly reports. The monthly reports, replaced by the annual reports, will be filed in a separate storage area as back-up to the annual reports. The monthly history reports will be retained for twelve months and the yearly reports for five years.

The Bureau will receive the detail reports on microfilm stored in microfilm cartridges. The number of cartridges the Bureau can expect to receive is approximately 16 per month in two groups. One group will contain the detail reports, the other group will contain the provider detail reports. The exact volume will depend upon the level or number of Medicaid claims for any given month.

The detail reports appear on the microfilm in order of their report number. For example, report PS02 is first; report PS06 is second, etc. The reports appear on the microfilm in continuous sequence, starting with report PS02. Thus one microfilm cartridge is likely to contain more than one detail report.

Each cartridge of microfilm will have its contents identified clearly on the exterior of the microfilm. The contents will be identified as follows:

a) Each cartridge will be numbered, showing its sequence number within the group. For example, Cartridge 1 of 7.

b) Each cartridge will be identified, indicating whether it is a provider or recipient detail report. The date of the report is shown also.

c) Each cartridge shows the starting and ending recipient or provider number of the contents.

d) Each cartridge identifies the internal location of a series of page numbers which show the starting and ending recipient or provider numbers for that group of pages.

For example, a cartridge for the recipient detail report for March 1970 is identified as depicted in Exhibit IV-1.

A microfilm cartridge identification report will accompany each group of microfilm cartridges. The identification report will list for each detail report, its location and the location of the report contents on the microfilm. An example of a cartridge identification report is included as Exhibit IV-2.

When cartridges have been received, about the 15th of the month, the following procedures is followed:

1) Verify that the number and contents of the microfilm cartridges matches the number and contents listed on the identification report. If the cartridges have not been labeled, return them to the liaison individual responsible for communications between the Bureau of Medical Care Surveillance and the Bureau of Data Processing, Department of the Treasury.

2) Verify that all of the recipient and provider detail reports are accounted for.

SAMPLE OF MICROFILM CARTRIDGE
IDENTIFICATION LABELS

IDENTIFICATION Cartridge 1 of 7 START 0110001209-01 END 0430005660-20	DATE March 1970 Recipient

Cartridge 1 of 7		March 1970	
Item	Index	Item RECIPIENT	Index
Page 1 0110001209-01	Start	0170000029-01	180
Page 881 0210005963-01	020	0270000081-01	200
Page 1318 0310000512-01	040	0370000013-01	220
Page 1727 0410003191-01	060	0430005660-20	240
	080		260
	100		280
	120		300
	140		320
	160		End

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CARTRIDGE IDENTIFICATION

May, 1970

COUNTY	CARTRIDGE	PAGE	BEGINNING---RECIPIENT---ENDING	
ATLANTIC	1	1	0110001209-01	0170000047-01
BERGEN	1	1010	0210003107-01	0270700086-01
BURLINGTON	1	1619	0310000512-01	0370000026-01
CAMDEN	1	2122	0410005627-01	0430000812-01
CAMDEN	2	2502	0430000812-02	0470000039-01
CAPE MAY	2	4244	0510001081-01	0570003569-01
CUMBERLAND	2	4401	0610000401-01	0670000004-01
ESSEX	2	4954	0710000202-01	0710028396-01
ESSEX	3	5002	0710023537-01	0730025898-01
ESSEX	4	7502	0730025896-20	0770044729-01
GLOUCESTER	4	9374	0810000501-01	0870000007-01
HUDSON	4	9701	0910002006-01	0930002021-22
HUDSON	5	10002	0930002027-22	0970000124-01
HUNTERDON	5	10340	1010001325-01	1070700006-01
MERCER	5	10955	1110002740-01	1170000026-01
MIDDLESEX	5	11725	1210000020-01	1270002069-01
MONMOUTH	5	12443	1310005980-01	1310012405-01
MONMOUTH	6	12502	1310012420-01	1370000069-01
MORRIS	6	13716	1410002925-01	1470000051-01
OCEAN	6	14002	1510000076-01	1570700066-01
PASSAIC	6	14529	1610005259-01	1630002554-23
PASSAIC	7	15002	1630002555-01	1670700023-01
SALEM	7	16346	1710001361-01	1770000011-01
SOMERSET	7	16516	1810000009-01	1870000018-01
SUSSEX	7	16705	1910001410-01	1970000009-01
UNION	7	16877	2010002487-01	2070000079-01
WARREN	7	17495	2110001757-01	2110003276-01
WARREN	8	17502	2110003283-01	2170000012-01

Exhibit IV-2.

3) Verify that all of the microfilm cartridges have been properly labeled and dated for identification.

4) File all of the monthly cartridges in sequence by cartridge number.

   The microfilm detail reports are stored in a storage cabinet designed for microfilm cartridges. Each month of cartridges will have a distinct (i.e. a drawer) and labeled location in the file cabinet.

5) If it appears that one or several cartridges are missing or something is incorrect, document the problem and notify immediately the individual responsible for liaision between the Bureau of Medical Care Surveillance the Bureau of Data Processing, Department of the Treasury.

Surveillance Exception Reports File

The surveillance exception reports are received monthly. The actual reports received should be the same as those requested by the Bureau by use of the criteria selection forms.

There will be two copies of each report. One copy is retained intact as a file copy; the other copy will be distributed for review by bureau staff.

When the reports are received the following procedure will be performed:

1) Verify that all of the reports requested have been received and are separately bound by report number.

2) Verify that each report has been dated and contains the summary statistics for that report on the last page.

3) Verify that selection criteria used by the computer surveillance system were the same as those submitted on the Selection Criteria Forms. The selection criteria are printed, along with the report headings, at the top of every page of a report. Check that the selection criteria at the top of the first page of every report match the selection criteria on the selection criteria forms. If any criterion does not match, notify The Bureau Chief so that a decision can be made to rerun the month's data, if necessary.

4) Distribute one copy of each report to the staff assigned to review and evaluate.

5) File the second copy in the area assigned for surveillance report storage.

Case Analysis File

The Case Analysis File is a numerical file by case number of all cases investigated by the Bureau.

The Case Analysis File may be subdivided into several classifications. For instance, there are a great many cases which can be classified as "Third Party Liability" or "out-of-state claims." Thus it can be desirable to divide the Case Analysis File into classifications which are representative of the types of cases investigated by the Bureau.

Initially, the Case Analysis File will be divided into at least two subdivisions:

- General cases
- Third Party Liability Cases

Within each subdivision, there will be three sections:

- Cases awaiting investigation
- Cases under investigation
- Cases terminated

When a new case is commenced, a bureau case number is assigned to the case. The case numbers are sequential and maintained by the Bureau starting at number 1. The case is filed in the section cases awaiting investigation. When the case is assigned, it is filed in the section, cases under investigation. And when investigation has been completed, the case is filed in the section, cases terminated.

All of the information pertaining to one case is placed in a file folder assigned to this case. The contents of a case folder should be organized in the following manner and contain the following information. The forms used are described in Section III.

1. A case analysis summary form must preface the case and should be the first page in the case file. The form is used to provide a capsule summary of the case.

2. The second set of pages are the investigation report pages. These pages show in detail the activity, results, and recommendations in the case.

3. The third set of pages is the investigations log. This log provides a current record showing the date and action of all investigation activity pertaining to the case.

4. All computer data, letters and other information should be attached to the appropriate forms or pages in the file. Such data can be included on a surveillance computer data for or a complaint form.

Recoveries of Money File

When cases have been completed to the point where money is being recovered from the recipient or provider, they will be filed in this file. When the recovery of money has been completed, they will be returned to the completed section of the Case Analysis File.

Case Register

The case register is a master list in numerical order of all cases which are under investigation. When the Bureau decides to investigate a case, the next number available in the case register is assigned and the following information is recorded in the case register:

1. case file number
2. date received
3. staff responsible for investigation
4. date case assigned
5. source of information
6. subject of investigation
7. case classification
8. status of case (completed, pending, referred, etc.) and date of completion when completed

An example of the case register is included as Exhibit IV-3.

EXHIBIT 17-1

SURVEILLANCE CASE REGISTER

TE EIVED	CASE FILE NUMBER	STAFF ASSIGNED	SOURCE OF INFORMATION	SUBJECT OF INVESTIGATION	CASE CLASSIFICATION
1/71	479	Mr. Goldberg 4/1/71	Passaic Co. Welfare Board	[redacted] Nursing Home Passaic Co.	NURSING HOME Possible understating of private resources/overcharging of Medicaid. DATE COMPLETED: 4/29/71
1/71	480	Dr. Hood 4/1/71	Dr. Steckert	[redacted] M.D.	PHYSICIAN Billing irregularity DATE COMPLETED: 4/23/71
1/71	481	Dr. Hood 4/1/71	Dr. Silber	[redacted] Rec.	OTHER INSURANCE
1/71	482	Dr. Hood 4/1/71	Dr. Silber	[redacted] M.D.	PHYSICIAN Private billing of clinic patients
1/71	483	Dr. Hood 4/1/71	Dr. Silber	[redacted] Hospital	HOSPITAL Possible duplication of billing
1/71	484	Mr. Houston 4/1/71	Computer	[redacted] Rec.	THIRD PARTY LIABILITY

Alphabetical Card File

The alphabetical card file is a master list in alphabetical order of all the providers and recipients who have been or who currently are under investigation. When the Bureau decides to investigate a case, the following information is recorded on the card file and the card is filed in alphabetical order:

1. name of recipient or provider
2. HSP number of recipient or provider
3. date assigned
4. case number
5. case classification
6. date completed and/or status of the case

An example of the card file is provided as Exhibit IV-4.

ALPHABETICAL CARD

[redacted] Marilyn Case File No. 0044

Recipient - HSP #0110-001209-01

Third Party Liability November 13, 1970

Under Investigation

SECTION V - SURVEILLANCE EXCEPTION AND DETAIL REPORTS

GENERAL

As discussed in Section II - Use of Surveillance Report Selection Criteria, the automated surveillance support system prepares two categories of reports, exception reports and detail reports, each of which are described in this section of the manual. Table V-1 presents a key to both the exception and detail reports.

EXCEPTION REPORTS

The exception reports are used to identify those providers and recipients, whose use of the Medicaid system exceeds the selection criteria specified by the Bureau of Medical Care Surveillance. The exception reports must be requested by the Bureau by the submission of selection criteria as specified in Section II.

On each exception report, the selection criteria used for the preparation of that report, will be printed at the beginning of the report. The selection criteria applies to the activity for that month and the data elements that are in conflict with the selection criteria will be followed by an asterisk. In addition to providing the data for the current month, exception reports will include lines that provide corresponding data on a year-to-date basis and for the prior year. The availability of this additional data will permit the investigator to evaluate whether the activity for the month, that resulted in a conflict with the selection criteria, was an exception to normal yearly use of the Medicaid program by the provider or recipient.

A detailed description of each of the exception reports follows:

Inpatient Hospital Surveillance Report (PS01) - Exhibit V-1

This report lists all inpatient hospitals whose activities during the month exceeded any of the seleciton criteria values.

The hospitals are arranged by provider number within county. The counties are listed in alphabetical order.

The information provided on the report is as follows for all discharged or deceased patients. The data is provided for the month, year-to-date, and the prior year.

1. Provider county or state: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the institution.

3. Provider name: the name of the institution.

4. Total charges - discharged recipients: the total dollar amount of charges submitted for all services rendered to discharged or deceased recipients.

5. Total ancillary charges: the total dollar amount of charges submitted for all services except room and board, rendered to discharged or deceased recipients.

6. Medicaid payments: the total dollar amount paid by the Medicaid program for all services rendered to discharged or deceased recipients.

7. Number of recipients discharged: the number of discharged or deceased Medicaid patients.

8. Average charge per discharged recipient: this data is computed by dividing Total Charges by Number of Recipients Discharged.

9. Average ancillary charge per discharged recipient: this data is computed by dividing Total Ancillary Charges by Number of Recipients Discharged.

10. Average length of stay per discharged recipient: this data is computed by dividing the total number of days of care for all discharged or deceased recipients by the Number of Recipients Discharged.

11. Percent of discharged recipients with more than AID (Approval by Individual Diagnosis) days: the number of discharged or deceased recipients whose length of stay exceeded the primary diagnosis AID days as a percent of the Number of Recipients Discharged.

12. Average excess AID days per discharged recipient: this data is computed by dividing the total number of days exceeding AID limits for discharged and deceased recipients by the Number of Recipients whose lengths of stay exceeded the AID days.

At the end of the report, current month, year-to-date, and prior year data, for the above data elements, will be provided for all exception and non-exception inpatient hospitals. This data will be used, by the investigators, against which comparisons of the exceptions may be made.

Selection criteria can be established for data elements 4 through 12 of the report. If any one of the elements for a hospital exceeds the selection criteria limit for that element, the hospital will be printed on the report and the data element marked by an asterisk.

This report also provides a comparison of services provided to Medicare and non-Medicare patients. Exhibit V-2 identifies the information contained in the summary.

Inpatient Hospital Diagnosis Report (PS03) - Exhibit V-3

This report lists all inpatient hospitals whose activities in the treatment of selected diagnoses during the month exceeded any of the selection criteria.

The hospitals are arranged by provider number within the selected diagnoses.

The information provided on the report is as follows for all discharged or deceased patients:

1. Primary diagnosis description: a description of the diagnosis that has been specified in the selection criteria.

2. Provider number: the Medicaid number of the institution.

3. Provider name: the name of the institution.

4. Total charges - discharged recipients: the total dollar charges submitted for all services rendered to discharged or deceased recipients.

5. Total ancillary charges: the total dollar charges submitted for all services except room and board, rendered to discharged or deceased recipients.

6. Medicaid payments: the total dollar amount paid by the Medicaid program for all services rendered to discharged or deceased recipients.

7. Number of recipients discharged: the number of discharged or deceased Medicaid patients.

8. Average charge per discharged recipient: this data is computed by dividing Total Charges by the Number of Recipients Discharged.

9. Average length of stay per discharged recipient: this data is computed by dividing the total number of days of care for all discharged or deceased recipients by the Number of Recipients Discharged.

10. Average excess AID days per discharged recipient: this data is computed by dividing the total number of days exceeding AID limits for discharged and deceased recipients by the Number of Recipients Discharged.

After each diagnosis section, a line summary will be printed containing the data for the above data elements for all exception and non exception hospitals.

Selection criteria can be set for elements 4 through 10. If any one of the elements for a hospital exceeds the selection criteria limit for that element the hospital will be printed on the report and the data element marked with an asterisk.

Outpatient Hospital Surveillance Report (PS04) - Exhibit V-4

This report lists all outpatient hospitals whose activities during the month exceeded any of the selection criteria values. The hospitals are arranged by provider number within county. The counties are listed in alphabetical order.

The information provided on the report is as follows. The data is provided for the month, year-to-date, and the prior year.

1. Provider county or state: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the institution.

3. Provider name: the name of the institution.

4. Total charges-all recipients: the total dollar charges submitted for all services rendered to all Medicaid recipients.

5. Medicaid payments-all recipients: the total dollar payments by the Medicaid program for all services rendered to Medicaid recipients.

6. Number of recipients: the total number of recipients who have received care from this institution, paid for by Medicaid.

7. Number of visits-all recipients: the total number of visits made to outpatient hospitals by all Medicaid recipients.

8. Average charge per recipient: this data is computed by dividing Total Charges-All Recipients by Number of Recipients.

9. Average charge per visit: this data is computed by dividing Total Charges-All Recipients by Number of Visits -All Recipients.

At the end of the report, current month, year-to-date, and prior year data, for the above data elements, will be provided for all exception and non-exception outpatient hospitals. This data will be used by the investigators for comparisons of the exceptions.

Selection criteria can be established for data elements 4 to 12 of the report.

Outpatient Clinic Surveillance Report (PS05) - Exhibit V-4

This report lists all outpatient clinics whose Medicaid activities during the month exceeded any of the selection criteria values.

The organization and content of the report is the same as the Outpatient Hospital Surveillance Report (PS04).

Physicians Surveillance Report (PS08) - Exhibit V-5

This report lists all physicians whose Medicaid activities during the month exceeded any of the selection criteria values. The physicians are arranged by provider number within county. The counties are listed in alphabetical order.

The information provided on the report is as follows. The data is provided for the month, year-to-date, and the prior year.

1. Provider county or state: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the physician.

3. Group code: a code which indicates whether the physician is a member of a group practice.

4. Provider name: the name of the practitioner.

5. Provider specialty description: an abbreviation describing the specialty of the physician.

6. Total charges-all recipients: the total dollar charges submitted for services rendered to all Medicaid recipients served by this physician.

7. Medicaid payments-all recipients: the total dollar payments by the Medicaid program for services rendered to all Medicaid recipients by this physician.

8. Number of recipients: the total number of recipients who have received care, from this physician, paid for by Medicaid.

9. Number of visits-all recipients: the total number of visits made with this physician by all Medicaid recipients.

10. Average charge per recipient: this data is computed by dividing Total Charges-All Recipients by Number of Recipients.

11. Average charge per visit: this data is computed by dividing Total Charges-All Recipients by Number of Visits-All Recipients.

12. Visits per recipient: this data is computed by dividing Number of Visits-All Recipients by Number of Recipients.

13. Out-of-office visits as a percent of total visits: the total number of out-of-office visits made by this physician as a percent of his total number of visits with recipients.

At the end of the report, current month, year-to-date, and prior year data, for the above data elements will be provided, for all exception and non-exception physicians. This data will be used by the investigators for comparisons of the exceptions.

Selection criteria can be established for data elements 6 through 13 of the report.

This report also includes a comparison of services provided by the physician to Medicare and non-Medicare patients. Exhibit V-6 identifies the information contained in the summary.

Podiatrists Surveillance Report (PS09) - Exhibit V-5

This report lists all podiatrists whose Medicaid activities during the month exceeded any of the selection criteria values.

The organization and content of the report is the same as the Physicians' Surveillance Report (PS08).

Optometrists Surveillance Report (PS10) - Exhibit V-5

This report lists all optometrists whose Medicaid activities during the month exceeded any of the selection criteria values.

The organization and content of the report is the same as the Physicians' Surveillance Report (PS08).

Dentists Surveillance Report (PS11) - Exhibit V-5

This report lists all dentists whose activities during the month exceeded any of the selection criteria values.

The organization and content of the report is the same as the Physicians' Surveillance Report (PS08).

The summary that is provided for the dentists is noted in Exhibit V-7.

Drug Surveillance Report (PS16) - Exhibit V-8

This report lists all pharmacies whose Medicaid activities during the month exceeded any of the selection criteria values. The pharmacies are arranged by provider number within county. The counties are listed in alphabetical order.

The information provided on the report is as follows. The data is provided for the month, year-to-date, and the prior year.

1. Provider county or state: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the pharmacy.

3. Provider name: the name of the pharmacy.

4. Medicaid payments-all recipients: the total dollar payments by the Medicaid program for drug services provided to Medicaid recipients by this pharmacy.

5. Number of recipients: the total number of recipients who have received drug services from this pharmacy, paid for by Medicaid.

6. Number of prescriptions: the total number of Medicaid prescriptions filled by the pharmacy.

7. Average paid per recipient: this data is computed by dividing Medicaid Payments - All Recipients by Number of Recipients.

8. Average paid per recipient: this data is computed by dividing Medicaid Payments - All Recipients by Number of Prescriptions.

9. Prescriptions per recipient: this data is computed by dividing Number of Prescriptions by Number of Recipients.

10. Refills as a percent of all prescriptions: the number of refill Medicaid prescriptions as a percent of all Medicaid prescriptions filled by this pharmacy.

11. Injectables as a percent of all prescriptions: the number of Medicaid injectable prescriptions as a percent of all Medicaid prescriptions filled by this pharmacy.

12. Prescriptions for recipients in long-term care facilities as a percent of all prescriptions: the number of Medicaid prescriptions which were dispensed for recipients in long-term care facilities as a percent of all Medicaid prescriptions dispensed by this pharmacy.

The the end of the report, current month, year-to-date, and prior year data for the above data elements will be provided for all exception and non-exception pharmacies. This data will be used by the investigators for comparisons of the exceptions.

Selection criteria can be set for elements 4 through 12 of the report.

Home Health Agencies Surveillance Report (PS18) - Exhibit V-9

This report lists all home health agencies whose Medicaid activities during the month exceeded any of the selection criteria values.

The home health agencies are arranged by provider number within county. The counties are listed in alphabetical order.

The information provided on the report is as follows. The data is provided for the month, year-to-date, and the prior year.

1. Provider county or state: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the agency.

3. Provider name: the name of the agency.

4. Total charges - all recipients: the total dollar charges submitted for services rendered by this agency to Medicaid recipients.

5. Medicaid payments - all recipients: the total dollar payments by the Medicaid program for services rendered to Medicaid recipients by this home health agency.

6. Number of recipients: the total number of recipients who have received services from this agency, paid for by Medicaid.

7. Number of visits - all recipients: the total number of visits made to all Medicaid recipients by this home health agency.

8. Average charge per recipient: this data is computed by dividing Total Charges - All Recipients by Number of Recipients.

9. Average charge per visit: this data is computed by dividing Total Charges - All Recipients by Number of Visits.

10. Visits per recipient: this data is computed by dividing Number of Visits by Number of Recipients.

At the end of the report, current month, year-to-date, and prior year data for the above data elements will be provided for all exception and non-exception home health agencies. This data will be used by the investigators for comparisons of the exceptions.

Selection criteria can be set for elements 4 through 10 of the report.

Skilled Nursing Home Surveillance Report (PS20) - Exhibit V-10

This report lists all nursing homes whose Medicaid activities during the month exceeded any of the selection criteria values.

The nursing homes are arranged by provider number within county. The counties are listed in alphabetical order.

The information provided on the report is as follows. The data is provided for the month, year-to-date, and the prior year.

1. Provider county or state: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the nursing home.

3. Provider name: the name of the nursing home.

4. Extended care facility code: a code that indicates whether the nursing home is an extended care facility.

5. Total charges - all recipients: the total dollar charges submitted for services rendered to all Medicaid recipients by this nursing home.

6. Total ancillary charges - all recipients: the total dollar charges submitted for all services, except room and board, rendered to all recipients by this nursing home.

7. Medicaid payments - all recipients: the total dollar payments by the Medicaid program for services rendered to all Medicaid recipients by this nursing home.

8. Number of recipients: the total number of recipients who have received care, by this nursing home, paid for by Medicaid.

9. Average charge per recipient: this data is computed by dividing Total Charges - All Recipients by Number of Recipients.

10. Average ancillary charges per recipient: this data is computed by dividing Total Ancillary Charges - All Recipients by Number of Recipients.

11. Average length of stay per recipient: this data is computed by dividing the total number of days of care in the nursing home for all recipients by the Number of Recipients.

12. Number of recipients greater than 120 days length of stay: the number of recipients whose length of stay exceeds 120 days.

At the end of the report, current month, year-to-date, and prior year data for the above data elements, will be provided, either in total or as an average, for all exception and non-exception nursing homes.

Selection criteria can be set for elements 5 through 12 of the report.

This report also includes a comparison of services provided by the nursing home to Medicare and non-Medicare patients. Exhibit V-11 identifies the information contained in the summary.

Special Services Surveillance Report (PS22) - Exhibit V-12

This report lists those providers of special services whose Medicaid activities during the month exceeded any of the selection criteria values. The special services are optical appliances, independent laboratories, transportation, medical supplies and equipment, and prosthetic and orthotic appliances.

A report is provided for each of the special services. Within each special services report, the providers are arranged by provider number within county.

The information provided on the report is as follows. The data is provided for the month, year-to-date, and the prior year.

1. Benefit code description: a description of the type of service for which the data on this report applies.

2. Provider county or state: the New Jersey county or other state where the provider supplies services.

3. Provider number: the Medicaid number of the special services provider.

4. Provider name: the name of the special services provider.

5. Total charges - all recipients: the total dollar charges submitted for services rendered to all Medicaid recipients by this provider of the special services.

6. Medicaid payments - all recipients: the total dollar payments by the Medicaid program for services rendered to all Medicaid recipients by this provider of special services.

7. Number or recipients: the total number of recipients who have received services from this provider, paid for by Medicaid.

8. Number of claims: the total number of unique claims that were processed for all recipients served by this provider.

9. Average charge per recipient: this data is computed by dividing Total Charges - All Recipients by Number of Recipients.

10. Average charge per claim: this data is computed by Total Charges - All Recipients by Number of Claims.

At the end of each requested category of special services, data is provided for all exception and non-exception providers in that special service category. The data, for the above data elements, is for the current month, year-to-date, and prior year.

Selection criteria may be set for elements 5 through 10 of the report.

Recipient Surveillance Report (PS24) - Exhibit V-13

This report lists those recipients whose use of Medicaid during the month exceeded any of the selection criteria values.

The report lists each recipient in order of recipient numbers.

The information contained in the report is as follows. The data is provided for the month, year-to-date, and the prior year.

1. Recipient number - a unique number assigned to each individual who is eligible to receive medical services under Medicaid.

   Digits 1-2 = recipient county
   Digits 3-4 = recipient category
   Digits 5-10 = case number
   Digits 11-12= person number

2. Recipient name: name of the recipient.

3. Recipient county: New Jersey county or state in which recipient lives.

4. Recipient age

5. Recipient sex

6. Program status code: a code which indicates a recipient's status in a welfare program category.

7. Previous number code: an asterisk which indicates whether this recipient has had another recipient number.

8. Inpatient care Medicaid payments: the total paid by Medicaid for inpatient hospital services received by the recipient.

9. Practitioners and outpatient care, number of visits: the total number of visits by the recipient to practitioners and outpatient care facilities.

10. Practitioners and outpatient care, Medicaid payments: the total dollars paid by Medicaid for all practitioner and outpatient care received by the recipient.

11. Nursing home Medicaid payments: the total dollars paid by Medicaid for all nursing home services received by the recipient.

12. Drug care - number of prescriptions: the total number of original prescriptions, paid for by Medicaid, dispensed for the recipient.

13. Drug care - Medicaid payments: the total dollars paid by Medicaid for all prescriptions dispensed for the recipient.

14. Home health Medicaid payments: the total dollars paid by Medicaid for all home health services received by the recipient.

15. Other services, Medicaid payments: the total dollars paid by Medicaid for all Medicaid services not included in data elements 8, 10, 11, 13 or 14.

16. Total Medicaid payments - all services: the total dollars paid by Medicaid for all services received by the recipient.

At the end of the report, current month, year-to-date, and prior year data will be provided for all exception and non-exception recipients.

Selection criteria can be set for elements 8 through 16 of the report.

Detail Reports

The detail reports provide a record of all claims paid by Medicaid during the month. For each type of provider, a microfilm detail report will list all of the recipients for whom the provider billed Medicaid. These reports will be used by the investigators to obtain supporting detail for those providers listed on the exception reports. The reports are generated monthly with a year-end report which combines all of the 12 preceding months.

A detailed description of each of the detail report follows.

Inpatient Hospital Detail Report (PS02) - Exhibit V-14

This report lists each claim submitted by each inpatient hospital for recipients who received treatment paid by Medicaid.

The hospitals are arranged in provider number order within county (counties are in alphabetical order). Within each hospital, the recipients are listed in recipient number order.

The information contained in the report is:

1. Provider county: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the institution.

3. Recipient number: a unique number assigned to an individual who is eligible to receive medical services under Medicaid.

4. Attending Practitioner Number: the IRS number of the attending practitioner for the services rendered in the claim.

5. Adjustment code: a code which indicates that the data contained in the record is an adjustment to a prior paid claim.

6. Claim number: a unique number assigned to each claim paid by the claims processing agent.

7. Recipient age: the age in years.

8. Recipient sex

9. Date of admission: the date the recipient was admitted to the hospital.

10. Date of discharge: date the recipient was discharged from the hospital.

11. Primary diagnosis code: a code which identifies the recipients' primary diagnosis at time of discharge (refer to the International Classification of Diseases, Adapted (Revision 8) for a list of diagnosis codes).

12. Primary procedure: a code which identifies the primary surgical procedure performed on a recipient for the service covered by the claim (refer to the 1964 Relative Value Studies of the California Medical Association for a list of procedure codes).

13. Excess AID days: the length of stay in excess of the AID days allowed for the primary diagnosis.

14. Discharge status code: a code which indicates the disposition of a recipient on the date of service (to) contained in the claim, such as discharged, deceased, still patient, etc.

15. Total charges - this claim: the total dollar charges submitted for services contained in this claim.

16. Medicaid Payment - this claim: the total dollars paid by Medicaid for services contained in this claim.

For each inpatient hospital, totals are provided for data elements 15 and 16, above.

OUTPATIENT HOSPITAL DETAIL REPORT (PS06) - Exhibit V-15

The report lists each claim submitted by each outpatient hospital for recipients who received treatments paid for by Medicaid.

The hospitals are arranged in provider number order within county (counties are in alphabetical order). Within each hospital, the recipients are listed in recipient number order.

The information contained in the report is:

1. Provider county: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the institution.

3. Recipient number: a unique number assigned to an individual who is eligible to receive medical services under Medicaid.

4. Referring Practitioner number: the IRS number of the attending or referring practitioner for the services rendered in the claim.

5. Adjustment code: a code which indicates that the data contained in the record is an adjustment to a prior paid claim.

6. Claim number: a unique number assigned to each claim paid by the claims processing agent.

7. Recipient age: the age in years.

8. Recipient sex.

9. Date of service (from): the date when services specified in the claim were started.

10. Date of service (to): the date when services specified in the claim ended.

11. Number of visits in period: the total number of visits included in the claim.

12. Service department or clinic type: a code which identifies the hospital department or the type of clinic which rendered the service indicated in the claim (refer to Table V-2 for a list of service department and clinic codes).

13. Primary diagnosis code: a code which identifies the primary diagnosis for the service covered by the claim.

14. Primary procedure code: a code which identifies the primary procedure performed on a recipient for the services covered by the claim.

15. Total charges - this claim: the total dollar charges submitted for services contained in this claim.

16. Medicaid Payment - this claim: the total dollars paid by Medicaid for services contained in this claim.

For each outpatient hospital, totals are provided for data elements 15 and 16, above.

Outpatient Clinic Detail Report (PS07) - Exhibit V-15

The report lists each claim submitted by each outpatient clinic for recipients who received treatments paid for by Medicaid.

The clinics are arranged in provider number order within county (counties are in alphabetical order). Within each clinic the recipients are listed in recipient number order.

The information contained in this report is the same as that on the Outpatient Hospital Detail Report (PS06).

Physicians Detail Report (PS12) - Exhibit V-16

This report lists each claim submitted by each physician for recipients who received treatment paid for by Medicaid.

The physicians are arranged in provider number order within county (counties are in alphabetical order). For each physician, his recipients are listed numerically by recipient number.

The information contained in the report is:

1. Provider county: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the practitioner.

3. Recipient number: a unique number assigned to an individual who is eligible to receive medical services under Medicaid.

4. Referring Practitioner number: the IRS number of the referring practitioner for the services rendered in the claim.

5. Adjustment code: a code which indicates that the data contained in the record is an adjustment to a prior paid claim.

6. Claim number: a unique number assigned to each claim paid by the claims processing agent.

7. Recipient age: the age in years.

8. Recipient sex.

9. Date of service (from): the date when services specified in the claim were started.

10. Date of service (to): the date when services specified in the claim ended.

11. Number of visits in period: the total number of visits (office, home, etc.) included in the claim.

12. Place of service: a code which describes where the service was performed.

13. Primary diagnosis code: a code which identifies the primary diagnosis for the service covered by the claim.

14. Primary procedure code: a code which identifies the primary procedure performed on a recipient for the services covered by the claim.

15. Total charges - this claim: the total dollar charges submitted for services contained in this claim.

16. Medicaid Payment - this claim: the total dollars paid by Medicaid for services contained in this claim.

For each physician, totals are provided for data elements 15 and 16, above.

Podiatrist Detail Report (PS13) - Exhibit V-16

The report lists all claims processed during the month for each participating podiatrist. The information contained in this report is the same as that on the Physicians Detail Report (PS12).

Optometrists Detail Report (PS14) - Exhibit V-16

The report lists all claims processed during the month for each participating optometrist. The information contained in this report is the same as that on the Physicians Detail Report (PS12).

Dentists Detail Report (PS15) - Exhibit V-16

The report lists all claims processed during the month for each participating dentist. The information contained in this report is the same as that on the Physicians Detail Report (PS12).

Drugs Detail Report (PS17) - Exhibit V-17

This report lists each claim submitted by each pharmacy for recipients whose prescriptions were paid for by Medicaid.

The pharmacies are arranged in provider number order within county (counties are in alphabetical order). For each pharmacy, the recipients are listed numerically by recipient number.

The information contained in the report is:

1. Provider county or state: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the pharmacy.

3. Recipient number: a unique number assigned to an individual who is eligible to receive medical services under Medicaid.

4. Prescriber number: the IRS number of the prescribing practitioner for the services rendered in the claim.

5. Adjustment code: a code which indicates that the data contained in the record is an adjustment to a prior paid claim.

6. Batch number: a number which indicates the batch in which a claim was processed by the claims processing agent.

7. Claim number: a unique number assigned to each claim paid by the claims processing agent.

8. Recipient age: the age in years.

9. Recipient sex.

10. Date dispensed: the date when a prescription was filled.

11. Prescription number: a unique code which identifies a prescription dispensed by the pharmacy.

12. Drug code: a national drug code assigned by the Federal Drug Administration which identifies the drug dispensed.

13. Drug name: the name of the drug identified by the drug code.

14. Quantity dispensed: the quantity of drug dispensed, expressed in the drug reporting code.

15. Days supply: the number of days a drug prescription should last the recipient.

16. Refill code: a number which indicates whether the prescription was an original prescription (0) or the number of times the prescription has been refilled (e.g., 1, 2, 3, etc.).

17. Long term care facility code: a code which indicates that the prescription dispensed was for a recipient in a long term care facility.

18. Special drug code: a code which identifies whether the drug dispensed was an injection, a vitamin, etc.

19. Medicaid payment-this claim: the total dollars paid by Medicaid for services contained in the claim.

For each pharmacist, a total is provided for Medicaid payments.

Home Health Agencies Detail Report (PS19) - Exhibit V-18

This report lists each claim submitted by each home health agency for recipients who received services paid for by Medicaid.

The agencies are arranged in provider number order within county (counties are in alphabetical order). For each home health agency, the recipients are listed numerically by recipient number.

The information contained in the report is:

1. Provider county or state: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the agency.

3. Recipient number: a unique number assigned to an individual who is eligible to receive medical services under Medicaid.

4. Attending Practitioner number: the IRS number of the referring practitioner for the services rendered in the claim.

5. Adjustment code: a code which indicates that the data contained in the record is an adjustment to a prior paid claim.

6. Claim number: a unique number assigned to each claim paid by the claims processing agent.

7. Recipient age: the age in years.

8. Recipient sex.

9. Date of service (from): the date when services specified in the claim were started.

10. Date of service (to): the date when services specified in the claim ended.

11. Number of visits in period: the total number of visits included in the claim.

12. Primary Diagnosis code: a code which identifies the primary diagnosis for the service covered by the claim.

13. Primary service description: a description of the primary service covered by the claim.

14. Total charges - this claim: the total dollar charges submitted for services contained in this claim.

15. Medicaid payment - this claim: the total dollars paid by Medicaid for services contained in this claim.

For each home health agency, totals are provided for data elements 14 and 15 above.

Skilled Nursing Home Detail Report (PS21) - Exhibit V-19

The report lists each claim submitted from each nursing home for recipients who received services paid for by Medicaid.

The nursing homes are arranged in provider number order within county (counties are in alphabetical order). For each nursing home, the recipients are listed numerically by recipient number.

The information contained in the report is:

1. Provider county or state: the New Jersey county or other state where the provider supplies services.

2. Provider number: the Medicaid number of the nursing home.

3. Recipient number: a unique number assigned to an individual who is eligible to receive medical services under Medicaid.

4. Attending Practitioner number: the IRS number of the attending or referring practitioner for the services rendered in the claim.

5. Adjustment code: a code which indicates that the data contained in the record is an adjustment to a prior paid claim.

6. Claim number: a unique number assigned to each claim paid by the claims processing agent.

7. Recipient age: the age in years.

8. Recipient sex.

9. Date of admission: the date the recipient was admitted to the nursing home.

10. Date of discharge: the date the recipient was discharged from the nursing home.

11. Primary diagnosis code: a code which identifies the primary diagnosis for the service covered by the claim.

12. Discharge status code: a code which indicates the disposition of the recipient as of the date of the claim (discharged, deceased, still patient, etc.)

13. Total charges - this claim: the total dollar charges submitted for services contained in this claim.

14. Medicaid payment - this claim: the total dollars paid by Medicaid for services contained in this claim.

For each nursing home, totals are provided for data elements 13 and 14 above.

Special Services Detail Report (PS23) - Exhibit V-20

The report lists all claims processed during the month for all suppliers of special services (optical appliances, independent laboratories, transportation, medical supplies and equipment, prosthetic and orthotic appliances).

The suppliers are arranged in provider number order within county (counties are in alphabetical order). For each supplier, the recipients are listed numerically by recipient number. There is a separate report for each of the five different types of suppliers.

The information contained in the report is:

1. Benefit code description: a description of the type of service for which the data on this report applies.

2. Provider county or state: the New Jersey county or or other state where the provider supplies services.

3. Provider number: the Medicaid number of the supplier.

4. Recipient number: a unique number assigned to an individual who is eligible to received medical services under Medicaid.

5. Attending Practitioner number: the IRS number of the prescribing or referring practitioner for the services rendered in the claim.

6. Adjustment code: a code which indicates that the data contained in the record is an adjustment to a prior paid claim.

7. Claim number: a unique number assigned to each claim paid by the claims processing agent.

8. Recipient age: the age in years.

9. Recipient sex.

10. Date of service: the date when services covered by the claim were provided.

11. Primary procedure code: a code which identifies the primary procedure performed or the item supplied to the recipient for the services in this claim.

12. Total charges - this claim: the total dollar charges submitted for services contained in this claim.

13. Medicaid payment - this claim: the total dollars paid by Medicaid for services contained in this claim.

For each supplier, totals are provided for data elements 12 and 13 above.

Recipient Profile Report (PS25) - Exhibit V-21

The report lists the individual paid claims for each recipient who received Medicaid assistance during the month. Each recipient is listed numerically by recipient number.

The paid claims for each recipient are listed in order of date of service (for services performed) or, in the case of drugs, the date dispensed.

The information contained in the report is:

A. Description of the recipient:

1. Recipient number: a unique number assigned to each individual who is eligible to receive medical services under Medicaid.

2. Recipient name: last name, first name and middle initial.

3. Recipient county or state: a description of the New Jersey county or other state.

4. Category description: a description of the welfare category to which a recipient belongs.

5. Program status code: a code which indicates a recipient's status in a welfare program category.

6. Recipient age.

7. Recipient sex.

8. Recipient race.

9. Marital status.

10. Previous number: the number, if any, assigned to the recipient prior to the current recipient number.

B. A description of all claims except drug claims.

1. Date of service from: the date when services covered by the claim were started.

2. Date of service to: the date when services covered by the claim ended.

3. Provider number: the Medicaid number of institutions and the IRS number of all other providers.

4. Provider type code (Benefit code): a code which identifies the type of provider that supplied the service contained in the paid claim.

5. Provider specialty description: an abbreviation describing the specialty, if any, of a provider.

6. Adjustment code: a code which indicates that the data contained in the record is an adjustment to a prior paid claim.

7. Claim number: a unique number assigned to each claim paid by the claims processing agents.

8. Primary diagnosis code: a code which identifies the recipient's primary diagnosis for the service covered by the claim.

9. Primary diagnosis description: a description of the primary diagnosis code.

10. Primary procedure code: a code which identifies the primary procedure performed or the item supplied for a recipient for the services covered by the claim.

11. Primary procedure code description: a description of the primary procedure code.

12. Psychiatric care code: a code which indicates whether the services contained in the claim were regular services or psychiatric services.

13. Place of service: the location where the service was performed (home, office, hospital).

14. Medicaid payment - this claim: the total dollars paid by Medicaid for services contained in the claim.

C. A description of all drug claims.

1. Date dispensed: the date when a prescription was filled.

2. Provider number: the prescription plan number of a drug supplier.

3. Prescriber number: the IRS number of the prescribing practitioner for the services rendered in the claim.

4. Adjustment code: a code which indicates that the data contained in the record is an adjustment to a prior paid claim.

5. Batch number: a number which indicates the batch in which a claim was processed.

6. Claim number: a unique number assigned to each claim paid by the claims processing agent.

7. Prescription number: a unique code which identifies a prescription dispensed by a pharmacy.

8. Drug code: a national drug code assigned by the Federal Drug Administration which identifies the drug dispensed.

9. Drug name: the name of the drug identified by the drug code.

10. Quantity dispensed: the quantity of drug dispensed expressed in the drug reporting code.

11. Days supply: the number of days a drug prescription should last the recipient (a function of quantity dispensed and the dosage amount and frequency).

12. Refill code: a code which indicates either that the prescription was an original prescription (o) or the number of times the prescription has been refilled (e.g., 1, 2, etc.)

13. Long term care facility code: a code which indicates that the prescription dispensed was for a recipient in a long term care facility.

14. Special drug code: a code which identifies whether the drug dispensed was an injection, a vitamin, etc.

15. Medicaid payment - this claim: the total dollars paid by Medicaid for services covered by the claim.

For each recipient, a total of all Medicaid payments is provided.

Prescriber Profile Report (PS26) - Exhibit V-22

The report lists each claim paid by Medicaid during the month for services initiated by the prescribing, attending or referring practitioner. For each prescriber, this detailed listing shows the provider and recipient of services initiated by him. (A prescriber is a practitioner who initiates a service, he is not the provider paid for the service).

The prescibers are listed numerically by number. For each prescriber, the claims "prescribed" by him are listed in chronological sequence by date of service.

The information contained in the report is:

A. Description of the prescriber

1. Prescriber number: the IRS number of the prescribing, attending or referring practitioner.

2. Prescriber name: same as provider name.

3. Prescriber county or state: a description of the New Jersey county where the prescriber practices.

4. Benefit code: a code which identifies the type of prescriber thatinitiated the service contained in the paid claim.

5. Prescriber specialty: a code which identifies the specialty of the practitioner who provided the service.

B. Description of drug claims

1. Recipient number: a unique number assigned to each individual who is eligible to receive medical services under Medicaid.

2. Date dispensed: the date when a prescription was filled.

3. Provider number: the prescription plan number of a drug supplier.

4. Adjustment code: a code which indicates that the data contained in the record is an adjustment to a prior paid claim.

5. Batch number: a number which indicates the batch in which a claim was processed.

6. Claim number: a unique number assigned to each claim paid by the claims processing agent.

7. Prescription number: a unique code which identifies a prescription dispensed by a pharmacy.

8. Drug code: a national drug code assigned by the Federal Drug Administration which identifies the drug dispensed.

9. Drug name: the name of the drug identified by the drug code.

10. Quantity dispensed: the quantity of drug dispensed expressed in the drug reporting code.

11. Days supply: the number of days a drug prescription should last the recipient (a function of quantity dispensed and the dosage amount and frequency).

12. Refill code: a code which indicates either that the prescription was an original prescription (o) or the number of times the prescription has been refilled (e.g., 1, 2, etc.).

13. Long term care facility code: a code which indicates whether the prescription dispensed was for a recipient in a long term care facility.

14. Special drug code: a code which identifies whether the drug dispensed was an injection, a vitamin, etc.

15. Medicaid payment - this claim: the total dollars paid by Medicaid for services covered by the claim.

C. Description of all other claims

1. Recipient number: a unique number assigned to each individual who is eligible to receive medical services under Medicaid.

2. Date of service from: the date when services covered by the claim was started.

3. Date of service to: the date when services covered by the claim ended.

4. Benefit code: a code which identifies the type of provider that supplied the service contained in a paid claim.

5. Provider number: the Medicaid number of institutions and the IRS number of all other providers.

6. Adjustment code: a code which indicates that the data contained in the record is an adjustment to a prior paid claim.

7. Claim number: a unique number assigned to each claim paid by the claims processing agents.

8. Number of visits or days: the total number of visits or the total number of days of service.

9. Primary diagnosis code: a code which identifies the recipient's primary diagnosis for the service covered by the claim.

10. Primary procedure code: a code which identifies the primary procedure performed or item supplied for the recipient for the services covered by the claim.

11. Medicaid payment - this claim: the total dollars paid by Medicaid for services covered by the claim.

For each prescriber, a total is provided of all Medicaid paid claims.

Table V-1

KEY TO PROVIDER AND RECIPIENT REPORTS

PROVIDER REPORTS

Benefit Code	PROVIDER TYPE	Surveillance Report Number: Exception	Surveillance Report Number: Detail (Microfilm)
01	Inpatient Hospital	PS01	PS02
01	Inpatient Hospital (Diagnosis)	PS03	PS02
02	Mental Hospital	PS01	PS02
03	T.B. Hospital	PS01	PS02
04	Outpatient Hospital	PS04	PS06
05	Outpatient Clinic	PS05	PS07
06	Physician	PS08	PS12
07	Podiatrist	PS09	PS13
08	Optometrist	PS10	PS14
09	Dentist	PS11	PS15
10	Pharmacy (Drugs)	PS16	PS17
11	Home Health Agency	PS18	PS19
12	Nursing Home	PS20	PS21
13	Optical Appliance	PS22	PS23
14	Lab	PS22	PS23
15	Ambulance	PS22	PS23
16	Medical Supply	PS22	PS23
17	Prosthetic Device	PS22	PS23
	Recipient Profile		
All	All	PS24	PS25
	Prescriber Profile		
All	All	-	PS26

Exhibit V-1 and
Exhibit V-2

REPORT PS01

FEBRUARY 1971

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

INPATIENT HOSPITAL SURVEILLANCE REPORT
DISCHARGED OR DECEASED RECIPIENTS

HUDSON COUNTY

PROVIDER NUMBER	PROVIDER NAME	TOTAL CHARGES	ANCILLARY CHARGES	MEDICAID PAYMENTS	NUMBER DSCHRD	CHG PER RECIPIENT	ANCILLARY CHG PER RECIPIENT	AVG STAY	% GTR AID DAY	AVG EXCES AID DAYS
SELECTION CRITERIA		G$25000	G$15000	G$25000	G 75	G $600	G $450	G 10	G 25.00	G 1
		XXXXXXXXXXXXXXXXXX				XXXXXXXXXXXXXXXXXX				
310016		43341.60 *	16817.20 *	36615.90 *	54	802.62 *	311.42	8	12.9	14*
THIS PROVIDER	YEAR-TO-DATE	99211.05	41859.55	82636.30	136	729.49	307.79	7	14.0	9
THIS PROVIDER	PRIOR YEAR	.00	.00	.00		.00	.00	0	0.0	0

		NUMBER OF RECIPIENTS	-PERCENT OF RECIPIENTS BY LENGTH OF STAY- 1-5 DAYS	6-10 DAYS	11-15 DAYS	16-20 DAYS	21-30 DAYS	OVER30 DAYS	AVG LNGTH STAY	---AMOUNT CHARGED---- PER DIEM	ANCILLARY SERVICES	TOTAL
RECIPIENTS WITHOUT MEDICARE PAYMENTS	MEDICAL PATIENTS	17	17.6	35.2	11.7	17.6	11.7	5.8	12	12923	8419	21343
	SURGICAL PATIENTS	18	50.0	44.4	0.0	0.0	0.0	5.5	9	8759	5503	14263
	OBSTETRIC PATIENTS	1	100.0	0.0	0.0	0.0	0.0	0.0		170		170
	PEDIATRIC PATIENTS	18	77.7	16.6	0.0	0.0	5.5	0.0	5	4671	2893	7564
	TOTAL	54	50.0	31.4	3.7	5.5	5.5	3.7	8	26524	16817	43341
RECIPIENTS WITH MEDICARE	MEDICAL PATIENTS		0.0	0.0	0.0	0.0	0.0	0.0				
	SURGICAL PATIENTS		0.0	0.0	0.0	0.0	0.0	0.0				
	TOTAL		0.0	0.0	0.0	0.0	0.0	0.0				
TOTAL RECIPIENTS WITH AND WITHOUT MEDICARE		54	50.0	31.4	3.7	5.5	5.5	3.7	8	26524	16817	43341

PROVIDER NUMBER	PROVIDER NAME	TOTAL CHARGES	ANCILLARY CHARGES	MEDICAID PAYMENTS	NUMBER DSCHRD	CHG PER RECIPIENT	ANCILLARY CHG PER RECIPIENT	AVG STAY	% GTR AID DAY	AVG EXCES AID DAYS
		XXXXXXXXXXXXXXXXXX				XXXXXXXXXXXXXXXXXX				
312005		9140.04	2598.04	4336.00	9	1015.56 *	288.67	17*	33.3*	30*
THIS PROVIDER	YEAR-TO-DATE	14462.38	3893.38	7628.00	14	1033.03	278.10	19	35.0	31
THIS PROVIDER	PRIOR YEAR	.00	.00	.00		.00	.00	0	0.0	0

		NUMBER OF RECIPIENTS	-PERCENT OF RECIPIENTS BY LENGTH OF STAY- 1-5 DAYS	6-10 DAYS	11-15 DAYS	16-20 DAYS	21-30 DAYS	OVER30 DAYS	AVG LNGTH STAY	---AMOUNT CHARGED---- PER DIEM	ANCILLARY SERVICES	TOTAL
RECIPIENTS WITHOUT MEDICARE PAYMENTS	MEDICAL PATIENTS	6	16.6	50.0	0.0	0.0	0.0	33.3	22	5585	2005	7590
	SURGICAL PATIENTS	1	0.0	0.0	100.0	0.0	0.0	0.0	14	785	356	1141
	OBSTETRIC PATIENTS		0.0	0.0	0.0	0.0	0.0	0.0				
	PEDIATRIC PATIENTS	1	100.0	0.0	0.0	0.0	0.0	0.0	2	120	236	356
	TOTAL	8	25.0	37.5	12.5	0.0	0.0	25.0	19	6490	2598	9088
RECIPIENTS WITH MEDICARE	MEDICAL PATIENTS	1	100.0	0.0	0.0	0.0	0.0	0.0		52		52
	SURGICAL PATIENTS		0.0	0.0	0.0	0.0	0.0	0.0				
	TOTAL	1	100.0	0.0	0.0	0.0	0.0	0.0		52		52
TOTAL RECIPIENTS WITH AND WITHOUT MEDICARE		9	33.3	33.3	11.1	0.0	0.0	22.2	17	6542	2598	9140

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT P503

SEPTEMBER 1970

INPATIENT HOSPITAL DIAGNOSIS SURVEILLANCE REPORT
DISCHARGED OR DECEASED RECIPIENTS

PRIMARY DIAGNOSIS DESCRIPTION	PROVIDER NUMBER	PROVIDER NAME	TOTAL CHARGES	ANCILLARY CHARGES	MEDICAID PAYMENTS	NUMBER DSCHRD	CHG PER RECIPIENT	AVG STAY	AVG EXCESS AID DAYS
SELECTION CRITERIA - DIAGNOSIS CODE 5400			G 5800	G 2500	G 5800	G 10	G 530	G 8	G 1
ACUTE APPENDICITIS	00310003		75	10	66	1	75	7.0	2.0*
ACUTE APPENDICITIS	00310026		593	368	311	1	593*	5.0	.0
ACUTE APPENDICITIS	00310029		1272	588	883	2	636*	7.5	1.0
ACUTE APPENDICITIS	00310036		745	517	227	1	745*	4.0	.0
ACUTE APPENDICITIS	00310044		929	481	550	1	929*	7.0	.0
ACUTE APPENDICITIS	00310049		896	532	416	1	896*	6.0	.0
ACUTE APPENDICITIS	00310064		1215	617	812	1	1215*	13.0*	5.0*
ACUTE APPENDICITIS	00310078		2984	1128	2485	3	994*	11.0*	4.0*
ACUTE APPENDICITIS	310001		507	217	365	1	507	4.0	4.0*
ACUTE APPENDICITIS	310022		2711	1271	1770	2	1355*	14.5*	14.5*
ACUTE APPENDICITIS	310067		2301	878	1680	3	767*	11.0*	11.0*
ACUTE APPENDICITIS	310073		1308	501	1190	3	436	6.3	6.3*
ACUTE APPENDICITIS	310075		355	130	373	1	355	5.0	5.0*
ACUTE APPENDICITIS	310079		402	194	236	1	402	4.0	4.0*
ACUTE APPENDICITIS	310084		508	247	546	1	508	9.0*	9.0*
ACUTE APPENDICITIS	310087		387	147	323	1	387	6.0	6.0*
ACUTE APPENDICITIS	310088		497	297	297	1	497	5.0	5.0*
STATE TOTAL - ALL PROVIDERS - THIS DIAGNOSIS-			20525	9474	14512	32	641	7.3	4.2

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT P504
FEBRUARY 1971

MIDDLESEX COUNTY — OUTPATIENT HOSPITAL SURVEILLANCE REPORT — PAGE 15

SELECTION CRITERIA	PROVIDER NUMBER	PROVIDER NAME	---ALL RECIPIENTS---- TOT CHARGE G$10000	PAYMENTS G$10000	----NUMBER OF--- RECIPIENT G 50	VISITS G 200	---CHARGE PER- RECIPNT G $40	VISIT G $10
	00310036		356.50	341.50	14	14	25.46	25.46*
THIS PROVIDER - YEAR-TO-DATE			1134.75	1037.25	43	41	26.39	27.68
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00
	00310038		22173.02 *	21492.27 *	530*	869*	41.83*	25.51*
THIS PROVIDER YEAR-TO-DATE			41758.32	39624.57	1085	1744	38.49	23.94
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00
	00310039		10034.15 *	9828.65	294*	443*	34.12	22.65*
THIS PROVIDER YEAR-TO-DATE			24151.55	23094.45	678	1027	35.62	23.52
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00
	00310070		3039.75	2778.50	196*	206*	15.50	14.75*
THIS PROVIDER YEAR-TO-DATE			19600.85	18822.35	891	1302	22.00	15.05
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00
	00310108		32.00	6.00	2	1	16.00	32.00*
THIS PROVIDER YEAR-TO-DATE			205.00	179.00	6	5	34.17	41.00
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00
	00312004		271.20	271.20	10	12	27.12	22.60*
THIS PROVIDER YEAR-TO-DATE			1052.75	1052.75	26	58	40.49	18.15
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT PS05
FEBRUARY 1971

PASSAIC COUNTY — OUTPATIENT CLINIC SURVEILLANCE REPORT — PAGE 5

	PROVIDER NUMBER	PROVIDER NAME	---ALL RECIPIENTS---- TOT CHARGE	PAYMENTS	----NUMBER OF--- RECIPIENT	VISITS	---CHARGE PER- RECIPNT	VISIT
SELECTION CRITERIA			G$10000	G$10000	G 100	G 400	$100	$25
	320084E		2034.00	2034.00	313*	339	6.49	6.00
THIS PROVIDER YEAR-TO-DATE			3378.00	3372.00	514	563	6.57	6.00
THIS PROVIDER : PRIOR YEAR			.00	.00			.00	.00

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT PLOB
FEBRUARY 1971

MIDDLESEX COUNTY — PHYSICIANS SURVEILLANCE REPORT — PAGE 224

PROVIDER NUMBER	G C	PROVIDER NAME	PROVIDER SPECIALTY	ALL RECIPIENTS TOTAL CHARGES	ALL RECIPIENTS MEDICAID PAYMENTS	NUMBER OF RECIPNT	NUMBER OF VISITS	CHARGE PER RECIPIENT	CHARGE PER VISIT	VISITS PER RECIPIENT	OUT OF OFFICE AS PERCENT OF TOTAL VISIT
SELECTION CRITERIA				G $2000	G $2000	G 50	G 70			G 5	
221898577			PEDIA	856.00	848.00	45	93*	19.02	9.20	2	30.1
THIS PROVIDER YEAR-TO-DATE				1956.00	1864.00	82	199	23.85	9.83	2	46.2
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00		0.0

RECIPIENTS WITHOUT MEDICARE PAYMENTS

	VISITS OFFICE	VISITS HOSP	VISITS OTHER	OTHER PROCEDURES LAB	OTHER PROCEDURES X-RAY	OTHER PROCEDURES SURGERY	OTHER PROCEDURES INJECT	OTHER PROCEDURES EKG	OTHER PROCEDURES OTHER	OTHER PROCEDURES TOTAL	TOT RECIPIENT WITH MEDICARE	TOTAL
AMOUNT PAID	546	209							101	856		856
NUMBER OF SERVICES	38	7							5	50		50
NUMBER OF CLAIMS	36	4							5	45		45
AMOUNT PAID PER SERVICE	14	29							20	17		17
AMOUNT PAID PER CLAIM	15	52							20	19		19
NUMB OF SVC PER CLAIM	1	2							1	1		1

PROVIDER NUMBER	G C	PROVIDER NAME	PROVIDER SPECIALTY	ALL RECIPIENTS TOTAL CHARGES	ALL RECIPIENTS MEDICAID PAYMENTS	NUMBER OF RECIPNT	NUMBER OF VISITS	CHARGE PER RECIPIENT	CHARGE PER VISIT	VISITS PER RECIPIENT	OUT OF OFFICE AS PERCENT OF TOTAL VISIT
221909826			ORT SU	1270.00	905.00	7	57	181.42	22.28	8*	82.4
THIS PROVIDER YEAR-TO-DATE				1851.00	1425.00	21	77	88.14	24.04	4	64.9
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00		0.0

RECIPIENTS WITHOUT MEDICARE PAYMENTS

	VISITS OFFICE	VISITS HOSP	VISITS OTHER	OTHER PROCEDURES LAB	OTHER PROCEDURES X-RAY	OTHER PROCEDURES SURGERY	OTHER PROCEDURES INJECT	OTHER PROCEDURES EKG	OTHER PROCEDURES OTHER	OTHER PROCEDURES TOTAL	TOT RECIPIENT WITH MEDICARE	TOTAL
AMOUNT PAID	45	435			120	645			25	1270		1270
NUMBER OF SERVICES	3	5			5	5			1	19		19
NUMBER OF CLAIMS	3	3			2	5			1	7		7
AMOUNT PAID PER SERVICE	15	87			24	129			25	66		66
AMOUNT PAID PER CLAIM	15	145			60	129			25	181		181
NUMB OF SVC PER CLAIM	1	2			3	1			1	3		3

PROVIDER NUMBER	G C	PROVIDER NAME	PROVIDER SPECIALTY	ALL RECIPIENTS TOTAL CHARGES	ALL RECIPIENTS MEDICAID PAYMENTS	NUMBER OF RECIPNT	NUMBER OF VISITS	CHARGE PER RECIPIENT	CHARGE PER VISIT	VISITS PER RECIPIENT	OUT OF OFFICE AS PERCENT OF TOTAL VISIT
262784373			ANES	3044.00 *	2991.00 *	174*	420*	17.49	7.24	2	6.1
THIS PROVIDER YEAR-TO-DATE				3928.80	3868.80	230	546	17.08	7.20	2	4.7
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00		0.0

RECIPIENTS WITHOUT MEDICARE PAYMENTS

	VISITS OFFICE	VISITS HOSP	VISITS OTHER	OTHER PROCEDURES LAB	OTHER PROCEDURES X-RAY	OTHER PROCEDURES SURGERY	OTHER PROCEDURES INJECT	OTHER PROCEDURES EKG	OTHER PROCEDURES OTHER	OTHER PROCEDURES TOTAL	TOT RECIPIENT WITH MEDICARE	TOTAL
AMOUNT PAID	2730	300							3030		14	3044
NUMBER OF SERVICES	192	6							198		1	199
NUMBER OF CLAIMS	191	6							195		1	196
AMOUNT PAID PER SERVICE	14	50							15		14	15
AMOUNT PAID PER CLAIM	14	50							15		14	15
NUMB OF SVC PER CLAIM	1	1							1		1	1

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT P509
FEBRUARY 1971

ESSEX COUNTY — PODIATRISTS SURVEILLANCE REPORT — PAGE 8

PROVIDER NUMBER	PROVIDER NAME	PROVIDER SPECIALTY	ALL RECIPIENTS: TOTAL CHARGES	ALL RECIPIENTS: MEDICAID PAYMENTS	NUMBER OF RECIPNT	NUMBER OF VISITS	CHARGE PER RECIPIENT	CHARGE PER VISIT	VISITS PER RECIPIENT	OUT OF OFFICE AS PERCENT OF TOTAL VISIT
SELECTION CRITERIA			G $500	G $500	G 30	G 60	G $15	G $10	G 4	G 25.00
135036464		PODIA	42.80	42.80	6	5	7.13	8.56	1	60.0*
THIS PROVIDER YEAR-TO-DATE			147.80	132.80	17	16	8.69	9.24	1	68.7
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
135260027		PODIA	6.00	6.00	1	1	6.00	6.00	1	100.0*
THIS PROVIDER YEAR-TO-DATE			24.00	24.00	4	4	6.00	6.00	1	50.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
135267234		PODIA	157.80	57.40	9	6	17.53*	26.30*	1	0.0
THIS PROVIDER YEAR-TO-DATE			224.20	109.40	18	9	12.46	24.91	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
135349510		PODIA	38.40	.00	1		38.40*	.00		0.0
THIS PROVIDER YEAR-TO-DATE			38.40	.00	1		38.40	.00		0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
140141931		PODIA	685.00 *	479.00	13	15	52.69*	45.66*	1	0.0
THIS PROVIDER YEAR-TO-DATE			848.00	542.20	26	18	32.62	47.11	1	5.5
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
142128890		PODIA	261.00	151.40	19	24	13.73	10.87*	1	0.0
THIS PROVIDER YEAR-TO-DATE			301.80	164.40	27	26	11.18	11.61	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
144169396		PODIA	750.00 *	187.50	1	1	750.00*	750.00*	1	100.0*
THIS PROVIDER YEAR-TO-DATE			1250.00	337.50	2	2	625.00	625.00	1	100.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
145266546		PODIA	310.00	190.00	2	17	155.00*	18.23*	9*	100.0*
THIS PROVIDER YEAR-TO-DATE			350.00	223.00	3	18	116.67	19.44	6	100.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
145267244		PODIA	35.00	35.00	1	1	35.00*	35.00*	1	0.0
THIS PROVIDER YEAR-TO-DATE			35.00	35.00	1	1	35.00	35.00	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
145267499		PODIA	2114.00 *	861.00 *	222*	77*	9.52	27.45*		100.0*
THIS PROVIDER YEAR-TO-DATE			3750.00	1167.00	517	109	7.27	34.50		99.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
145268872		PODIA	10.00	6.00	1	1	10.00	10.00	1	100.0*
THIS PROVIDER YEAR-TO-DATE			10.00	6.00	1	1	10.00	10.00	1	100.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
14526928		PODIA	662.20 *	45[illegible]	81*	63*	8.17	10.51*	1	.9*
THIS PROVIDER YEAR-TO-DATE			1324.20	894.3	165	124	8.03	10.68	1	.2
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT PS10

FEBRUARY 1971

CAMDEN COUNTY

OPTOMETRISTS SURVEILLANCE REPORT

PAGE

PROVIDER NUMBER G C	PROVIDER NAME	PROVIDER SPECIALTY	ALL RECIPIENTS - TOTAL CHARGES	ALL RECIPIENTS - MEDICAID PAYMENTS	ALL RECIPIENTS - NUMBER OF RECIPNT	ALL RECIPIENTS - NUMBER OF VISITS	CHARGE PER RECIPIENT	CHARGE PER VISIT	VISITS PER RECIPIENT	OUT OF OFFICE AS PERCENT OF TOTAL VISIT
SELECTION CRITERIA			G $1000	G $1000	G 30	G 35	G $35	G $20	G 2	G 10.00
014183212		OPTOM	330.00	325.00	21	23	15.71	14.34	1	21.7*
THIS PROVIDER YEAR-TO-DATE			510.00	505.00	33	35	15.45	14.57	1	17.1
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
139032527		OPTOM	615.00	615.00	41*	41*	15.00	15.00	1	0.0
THIS PROVIDER YEAR-TO-DATE			930.00	930.00	62	62	15.00	15.00	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
140120777		OPTOM	2040.00 *	2040.00 *	135*	136*	15.11	15.00	1	0.0
THIS PROVIDER YEAR-TO-DATE			2835.00	2835.00	188	189	15.08	15.00	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
143165413		OPTOM	845.00	845.00	57*	57*	14.82	14.82	1	0.0
THIS PROVIDER YEAR-TO-DATE			1145.00	1145.00	77	77	14.87	14.87	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
143222789		OPTOM	455.00	435.00	32*	37*	14.21	12.29	1	0.0
THIS PROVIDER YEAR-TO-DATE			685.00	665.00	48	55	14.27	12.45	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
147126913		OPTOM	444.00	330.00	22	22	20.18	20.18*	1	0.0
THIS PROVIDER YEAR-TO-DATE			620.00	495.00	33	33	18.79	18.79	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
149121920		OPTOM	103.00	98.00	7	8	14.71	12.87	1	12.5*
THIS PROVIDER YEAR-TO-DATE			370.00	365.00	28	32	13.21	11.56	1	3.1
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
155079501		OPTOM	1410.00 *	1410.00 *	94*	94*	15.00	15.00	1	0.0
THIS PROVIDER YEAR-TO-DATE			1815.00	1815.00	121	121	15.00	15.00	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
156123484		OPTOM	600.00	600.00	40*	40*	15.00	15.00	1	0.0
THIS PROVIDER YEAR-TO-DATE			940.00	930.00	62	62	15.16	15.16	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
166340718		OPTOM	480.00	480.00	32*	32	15.00	15.00	1	0.0
THIS PROVIDER YEAR-TO-DATE			910.00	910.00	63	64	14.44	14.22	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
181095296		OPTOM	1290.00 *	1290.00 *	86*	86*	15.00	15.00	1	0.0
THIS PROVIDER YEAR-TO-DATE			2025.00	2025.00	135	135	15.00	15.00	1	0.0
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0
185326506		OPTOM	195.00	195.00	13	13	15.00	15.00	1	15.3*
THIS PROVIDER YEAR-TO-DATE			195.00	195.00	13	13	15.00	15.00	1	15.3
THIS PROVIDER PRIOR YEAR			.00	.00			.00	.00		0.0

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT PS11

FEBRUARY 1971

CAMDEN COUNTY — DENTISTS SURVEILLANCE REPORT — PAGE 31

PROVIDER NUMBER	G C	PROVIDER NAME	PROVIDER SPECIALTY	ALL RECIPIENTS TOTAL CHARGES	ALL RECIPIENTS MEDICAID PAYMENTS	ALL RECIPIENTS NUMBER RECIPNT	ALL RECIPIENTS NUMBER OF SERV	CHARGE PER RECIPIENT	CHARGE PER SERV	SERV PER RECIPIENT	OUT OF OFFICE AS PERCENT OF TOTAL VISIT
SELECTION CRITERIA				G $2000	G $40	G 40		G $75			
136246594			DMD	998.00	998.00	8	49	124.75*	20.36	6	0.0
THIS PROVIDER YEAR-TO-DATE				2538.00	2538.00	18	101	141.00	25.13	6	0.0
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00		0.0

	EXAMS	XRAY	PROPHY-LAXIS	FILL-INGS	CROWNS AND BRIDGES	EXTRAC-TIONS	OTHER ORAL SURGERY	ORTHO-DONTICS	PERI-DONTICS	ENDO-DONTICS	DENTURES	OTHER SERVICES	TOTAL
AMOUNT CHARGED	28	45	22	200	90	37			6		570		998
NUMBER OF SERVICES	6	13	4	16	1	4			1		4		49
NO RECIPIENTS SERVICED	6	7	1	4	1	2					2		8
AMT CHGD PER SERVICE	4	3	5	12	90	9			6		142		20
AMT CHGD PER RECIP	4	6	22	50	90	18					285		124
AMT OF SERV PER RECIP	1	1	4	4	1	2					2		6

138247863			DMD	1736.00	1736.00	13	66	133.53*	26.30	5			0.0
THIS PROVIDER YEAR-TO-DATE				3176.00	3176.00	39	221	81.44	14.37	6			0.0
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00				0.0

	EXAMS	XRAY	PROPHY-LAXIS	FILL-INGS	CROWNS AND BRIDGES	EXTRAC-TIONS	OTHER ORAL SURGERY	ORTHO-DONTICS	PERI-DONTICS	ENDO-DONTICS	DENTURES	OTHER SERVICES	TOTAL
AMOUNT CHARGED	40	60	60	205	90	28				50	1200	3	1736
NUMBER OF SERVICES	8	18	12	13	1	4				1	8	1	66
NO RECIPIENTS SERVICED	8	11	6	6		3				1	4	1	13
AMT CHGD PER SERVICE	5	3	5	15	90	7				50	150	3	26
AMT CHGD PER RECIP	5	5	10	34		9				50	300	3	133
AMT OF SERV PER RECIP	1	1	2	2		1				1	2	1	5

138283931			DMD	698.00	698.00	8	42	87.25*	16.61	5			0.0
THIS PROVIDER YEAR-TO-DATE				1322.00	1322.00	14	79	94.43	16.73	6			0.0
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00				0.0

	EXAMS	XRAY	PROPHY-LAXIS	FILL-INGS	CROWNS AND BRIDGES	EXTRAC-TIONS	OTHER ORAL SURGERY	ORTHO-DONTICS	PERI-DONTICS	ENDO-DONTICS	DENTURES	OTHER SERVICES	TOTAL
AMOUNT CHARGED	25	34	35	389		35	30				150		698
NUMBER OF SERVICES	5	12	5	12		5	2				1		42
NO RECIPIENTS SERVICED	5	7	5	1		3	1						8
AMT CHGD PER SERVICE	5	2	7	32		7	15				150		16
AMT CHGD PER RECIP	5	4	7	389		11	30						87
AMT OF SERV PER RECIP	1	1	1	12		1	2						5

Exhibit V-8

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT PS1A
FEBRUARY 1971

ESSEX COUNTY — DRUGS SURVEILLANCE REPORT — PAGE 35

PROVIDER NUMBER	PROVIDER NAME	PAYMENTS-ALL RECIPIENTS	NUMBER OF RECIPIENTS	NUMBER OF PRESCRIPTION	AV PER RECIPT	AVG PER RX	RX PER RECIPNT	REFILL % RX	INJECT % RX	LTC % RX
SELECTION CRITERIA		G $5000	G 1000	G 1250	G $10 G	$4 G	5 G	10.00 G	10.00 G	10.00
28004648		36.23	5	9	7.24	4.02*	1	0.0	0.0	0.0
THIS PROVIDER	YEAR-TO-DATE	36.23	5	9	7.25	4.03	2	0.0	0.0	0.0
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0
28005189		63.02	6	14	10.50*	4.50*	2	7.1	0.0	14.2*
THIS PROVIDER	YEAR-TO-DATE	278.99	16	60	17.44	4.65	4	8.3	0.0	3.3
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0
28005270		4836.37	474	1174	10.20*	4.11*	2	5.4	0.0	0.0
THIS PROVIDER	YEAR-TO-DATE	7147.75	751	1743	9.52	4.10	2	7.1	0.0	0.0
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0
28005700		7.30	2	2	3.65	3.65	1	50.0*	0.0	0.0
THIS PROVIDER	YEAR-TO-DATE	73.50	6	19	12.25	3.87	3	36.8	0.0	0.0
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0
28005718		34.65	3	5	11.55*	6.93*	1	40.0*	0.0	0.0
THIS PROVIDER	YEAR-TO-DATE	260.18	19	58	13.69	4.49	3	29.3	0.0	0.0
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0
28005775		6688.54 *	879	1666*	7.60	4.01*	1	59.6*	0.0	0.0
THIS PROVIDER	YEAR-TO-DATE	13718.75	1784	3492	7.69	3.93	2	56.2	0.0	0.0
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0
28005839		151.70	19	43	7.98	3.52	2	72.0*	0.0	30.2*
THIS PROVIDER	YEAR-TO-DATE	238.11	29	64	8.21	3.72	2	71.8	0.0	29.6
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0
28005841		188.74	19	44	9.93	4.28*	2	9.0	0.0	0.0
THIS PROVIDER	YEAR-TO-DATE	281.70	34	68	8.29	4.14	2	8.8	0.0	0.0
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0
28006054		5905.01 *	775	1468*	7.61	4.02*	1	16.4*	0.0	0.0
THIS PROVIDER	YEAR-TO-DATE	11403.90	1437	2815	7.94	4.05	2	15.1	0.0	0.0
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0
28006088		771.24	87	190	8.86	4.05*	2	4.7	0.0	0.0
THIS PROVIDER	YEAR-TO-DATE	1327.90	157	344	7.95	3.86	2	3.4	0.0	0.2
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0
28006229		416.03	51	96	8.15	4.33*	1	19.7*	0.0	1.0
THIS PROVIDER	YEAR-TO-DATE	899.63	110	207	8.18	4.35	2	14.0	0.0	0.4
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0
28006245		439.81	39	122	11.27*	3.60	3	9.0	0.0	0.0
THIS PROVIDER	YEAR-TO-DATE	716.16	70	197	10.23	3.64	3	8.6	0.0	0.0
THIS PROVIDER	PRIOR YEAR	.00			.00	.00	0	0.0	0.0	0.0

Exhibit V-9

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT PS1R
FEBRUARY 1971

PASSAIC COUNTY — HOME HEALTH AGENCIES SURVEILLANCE REPORT — PAGE 15

	PROVIDER NUMBER	PROVIDER NAME	TOTAL CHARGES	PMTS-ALL RECIPIENTS	NUMBER OF RECIPIENTS	NUMBER VISITS	--AVERAGE CHARGE-- RECIPIENT	VISIT	VISIT PR RECIPIENT
SELECTION CRITERIA			G $500	G $500	G 30	G 250	G $50	G $10	G 6
	00317004		573.25 *	573.25 *	12	46	47.77	12.46 *	3
THIS PROVIDER	YEAR-TO-DATE		830.25	830.25	19	68	43.70	12.21	4
THIS PROVIDER	PRIOR YEAR		.00	.00			.00	.00	0
	00317017		838.42 *	838.42 *	3	39	279.47 *	21.49 *	13*
THIS PROVIDER	YEAR-TO-DATE		1612.52	1612.52	6	67	268.75	24.07	11
THIS PROVIDER	PRIOR YEAR		.00	.00			.00	.00	0
	00317053		208.70	208.70	1	10	208.70 *	20.87 *	10*
THIS PROVIDER	YEAR-TO-DATE		208.70	208.70	1	10	208.70	20.87	10
THIS PROVIDER	PRIOR YEAR		.00	.00			.00	.00	0
	317049		1032.15 *	1032.15 *	9	79	114.68 *	13.06 *	8*
THIS PROVIDER	YEAR-TO-DATE		1406.40	1393.15	13	108	108.18	13.02	8
THIS PROVIDER	PRIOR YEAR		.00	.00			.00	.00	0

Exhibit V-10

[illegible] DATA ELEMENT
[illegible]
PROVIDER COUNTY
PROVIDER NUMBER

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

SKILLED NURSING HOME SURVEILLANCE REPORT

REPORT XXXX
MONTH 19XX
PAGE XXXX

	1	2	3	4	5		6		7		8		9		10	
	PROVIDER COUNTY (OR STATE) DESCRIPTION	PROVIDER NUMBER	PROVIDER NAME	EXTENDED CARE FACILITY CODE	TOTAL CHARGES–ALL RECIPIENTS	FLAG	TOTAL ANCILLARY CHARGES –ALL RECIPIENTS	FLAG	MEDICAID PAYMENTS– ALL RECIPIENTS	FLAG	NUMBER OF RECIPIENTS	FLAG	AVERAGE CHARGE PER RECIPIENT	FLAG	AVERAGE ANCILLARY CHARGES PER RECIPIENT	FLAG
DATA ELEMENT NUMBER	301	203	100	259	313		332		314		315		317		333	
THIS PROVIDER –		YTD / PY			EXCEPTION CRITERIA ELEMENTS →											
AT END OF REPORT ALL PROVIDERS		MO / YTD / PY														

	11		12	
	AVERAGE LENGTH OF STAY PER RECIPIENT	FLAG	NUMBER OF RECIPIENTS GREATER THAN 120 DAYS LENGTH OF STAY	FLAG
DATA ELEMENT NUMBER	334		335	

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FOLD TO DASHED LINE

Exhibit V-11

SOURCE DATA ELEMENT

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

SKILLED NURSING HOME SURVEILLANCE - SUMMARY

REPORT XXXX
MONTH, 19 XX
PAGE XXXX

		Number Of Recipients Serviced	Percent of Recipients by Length of Stay					Average Length Of Stay	Amount Paid This Period		
			30 Days Or Less	30-60 Days	61-90 Days	91-120 Days	Over 120 Days		Per Diem	Ancillary Services	Total
Recipients Without Medicare Payment	Residents										
	Discharges										
	Deaths										
Recipients With Medicare Payment	Residents										
	Discharges										
	Deaths										
All Recipients	Residents										
	Discharges										
	Deaths										

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COUNTY	PROVIDER NUMBER	PROVIDER NAME	SPLTY	---ALL RECIPIENTS---- TOT CHARGE	PAYMENTS	----NUMBER OF---- RECIPIENT	CLAIMS	---CHARGE PER- RECIPNT	CLAIM
SELECTION CRITERIA				G $1000	G $1000 G	30 G	30	G $30 G	$25
THIS PROVIDER YEAR-TO-DATE				1995.64	1913.74	85	87	23.48	22.94
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	220731174		UNKN	326.35	326.35	13	13	25.10	25.10*
THIS PROVIDER YEAR-TO-DATE				837.85	817.55	33	33	25.39	25.39
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221898462		UNKN	1409.89 *	1390.19 *	58*	58*	24.30	24.30
THIS PROVIDER YEAR-TO-DATE				4838.66	4752.76	191	193	25.33	25.07
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	900600545		UNKN	145.00	145.00	1	1	145.00*	145.00*
THIS PROVIDER YEAR-TO-DATE				305.00	305.00	2	2	152.50	152.50
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
GLOUCESTER	108142712		UNKN	58.95	49.55	2	2	29.47	29.47*
THIS PROVIDER YEAR-TO-DATE				110.04	95.64	4	4	27.51	27.51
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
GLOUCESTER	158079487		UNKN	248.35	204.40	8	8	31.04*	31.04*
THIS PROVIDER YEAR-TO-DATE				299.55	255.60	10	10	29.96	29.96
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
GLOUCESTER	171019546		UNKN	176.45	162.85	7	7	25.20	25.20*
THIS PROVIDER YEAR-TO-DATE				271.35	257.75	11	11	24.67	24.67
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
GLOUCESTER	179075256		UNKN	545.15	451.50	19	19	28.69	28.69*
THIS PROVIDER YEAR-TO-DATE				998.00	904.35	38	38	26.26	26.26
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSON	017128196		UNKN	751.99	741.59	40*	40*	18.79	18.79
THIS PROVIDER YEAR-TO-DATE				2051.65	2037.51	110	110	18.65	18.65
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSON	054207434		UNKN	66.60	66.60	2	3	33.30*	22.20
THIS PROVIDER YEAR-TO-DATE				89.50	89.50	3	4	29.83	22.38
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSON	112161167		UNKN	1700.82 *	1689.82 *	57*	65*	29.83	25.77*
THIS PROVIDER YEAR-TO-DATE				3245.87	3218.62	114	125	28.47	25.97
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSON	147181283		UNKN	34.50	34.50	1	1	34.50*	34.50*
THIS PROVIDER YEAR-TO-DATE				34.50	34.50	1	1	34.50	34.50
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSO	157306905		NKN	462.50	460.50	18	18	25.69	25.69*

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT PS22
FEBRUARY 1971

LABORATORY — SPECIAL SERVICES SURVEILLANCE REPORT — PAGE 15

COUNTY / SELECTION CRITERIA	PROVIDER NUMBER	PROVIDER NAME	SPLTY	---ALL RECIPIENTS---- TOT CHARGE	PAYMENTS	----NUMBER OF---- RECIPIENT	CLAIMS	---CHARGE PER- RECIPNT	CLAIM
				G $600	G $600	G 60	G 60	G $10	G $10
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	148122220		UNKN	547.00	531.70	24	26	22.79*	21.03*
THIS PROVIDER YEAR-TO-DATE				913.20	871.40	42	47	21.74	18.43
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221439936		UNKN	1631.90 *	1497.60 *	115*	130*	14.19*	12.55*
THIS PROVIDER YEAR-TO-DATE				2922.60	2558.20	216	251	13.53	11.64
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	540840780		UNKN	2450.10 *	2181.70 *	198*	208*	12.37*	11.77*
THIS PROVIDER YEAR-TO-DATE				6735.30	5907.50	475	506	14.18	13.31
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
GLOUCESTER	444281671		UNKN	271.00	256.50	17	18	15.94*	15.05*
THIS PROVIDER YEAR-TO-DATE				403.00	383.50	23	24	17.52	16.79
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSON	220937290		UNKN	2326.50 *	2298.50 *	139*	146*	16.73*	15.93*
THIS PROVIDER YEAR-TO-DATE				4519.00	4449.50	267	282	16.93	16.02
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSON	220937744		UNKN	107.00	107.00	9	9	11.88*	11.88*
THIS PROVIDER YEAR-TO-DATE				159.00	159.00	16	16	9.94	9.94
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSON	221619346		UNKN	66.00	55.00	2	3	33.00*	22.00*
THIS PROVIDER YEAR-TO-DATE				106.00	70.00	3	4	35.33	26.50
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSON	221690789		UNKN	289.00	175.50	16	18	18.06*	16.05*
THIS PROVIDER YEAR-TO-DATE				389.40	231.00	27	30	14.42	12.98
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSON	221859833		UNKN	70.00	58.00	2	2	35.00*	35.00*
THIS PROVIDER YEAR-TO-DATE				77.00	63.00	3	3	25.67	25.67
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSON	221867057		UNKN	142.60	126.50	13	13	10.96*	10.96*
THIS PROVIDER YEAR-TO-DATE				222.60	194.50	18	18	12.37	12.37
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
HUDSON	221897913		UNKN	464.00	373.50	23	25	20.17*	18.66*
THIS PROVIDER YEAR-TO-DATE				1554.00	1245.00	72	78	21.58	19.92
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
MERCER	108206990		UNKN	278.50	234.50	17	17	16.38*	16.38*

STATE OF NEW JERSEY
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DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

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AMBULANCE-TRANSPORT — SPECIAL SERVICES SURVEILLANCE REPORT — PAGE 20

COUNTY / SELECTION CRITERIA	PROVIDER NUMBER	PROVIDER NAME	SPLTY	---ALL RECIPIENTS---- TOT CHARGE	PAYMENTS	----NUMBER OF--- RECIPIENT	CLAIMS	---CHARGE PER- RECIPNT	CLAIM
				G $300	G $300	G 10	10	G $30	G $30
ATLANTIC	221773705		UNKN	463.20 *	253.80	20*	21*	23.16	22.05
THIS PROVIDER YEAR-TO-DATE				2142.00	1413.80	73	78	29.34	27.46
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
BERGEN	221892785		UNKN	700.60 *	472.40 *	10	10	70.06*	70.05*
THIS PROVIDER YEAR-TO-DATE				2662.60	1887.40	39	48	68.27	55.47
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221337995		UNKN	299.20	294.20	18*	20*	16.62	14.96
THIS PROVIDER YEAR-TO-DATE				491.20	486.20	28	30	17.54	16.37
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221643933		UNKN	163.60	134.00	11*	11*	14.87	14.87
THIS PROVIDER YEAR-TO-DATE				1364.20	1031.40	41	43	33.27	31.73
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221909390		UNKN	1006.56 *	889.36 *	42*	48*	23.96	20.97
THIS PROVIDER YEAR-TO-DATE				1759.16	1528.56	64	73	27.49	24.10
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
MONMOUTH	221838144		UNKN	371.20 *	271.20	20*	21*	18.56	17.67
THIS PROVIDER YEAR-TO-DATE				854.00	622.78	38	40	22.47	21.35
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
MONMOUTH	221906142		UNKN	1091.90 *	1010.70 *	20*	28*	54.59*	38.99*
THIS PROVIDER YEAR-TO-DATE				1325.90	1235.70	22	30	60.27	44.20
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
OCEAN	221830412		UNKN	1426.16 *	1221.76 *	31*	45*	46.00*	31.69*
THIS PROVIDER YEAR-TO-DATE				1724.66	1513.06	38	54	45.39	31.34
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
PASSAIC	145181053		UNKN	262.00	121.60	6	7	43.66*	37.42*
THIS PROVIDER YEAR-TO-DATE				525.60	262.40	16	17	32.85	30.93
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
PASSAIC	221738857		UNKN	839.40 *	803.40 *	51*	55*	16.45	15.26
THIS PROVIDER YEAR-TO-DATE				1695.00	1598.80	90	102	18.83	15.52
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
UN	221841327		UNKN	560.00 *	443.60 *	16*	18*	35.00	31.11*

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT P522
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MEDICAL SUPPLIES — SPECIAL SERVICES SURVEILLANCE REPORT — PAGE 32

COUNTY / SELECTION CRITERIA	PROVIDER NUMBER	PROVIDER NAME	SPLTY	---ALL RECIPIENTS---- TOT CHARGE	PAYMENTS	----NUMBER OF--- RECIPIENT	CLAIMS	---CHARGE PER- RECIPNT	CLAIM
				G $400	G $400	G 40	G 40	G $10	G $10
THIS PROVIDER YEAR-TO-DATE				43.50	43.50	4	4	10.88	10.88
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
OCEAN	210735976		UNKN	13.95	13.95	1	1	13.95*	13.95*
THIS PROVIDER YEAR-TO-DATE				13.95	13.95	1	1	13.95	13.95
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
OCEAN	210736750		UNKN	246.27	230.32	14	18	17.59*	13.68*
THIS PROVIDER YEAR-TO-DATE				774.77	755.87	28	35	27.67	22.14
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
OCEAN	210745264		UNKN	35.95	33.06	2	3	17.97*	11.98*
THIS PROVIDER YEAR-TO-DATE				35.95	33.06	2	3	17.98	11.98
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
OCEAN	221865677		UNKN	92.00	92.00	1	2	92.00*	46.00*
THIS PROVIDER YEAR-TO-DATE				127.95	127.95	3	4	42.65	31.99
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
OCEAN	221909259		UNKN	54.40	54.40	1	1	54.40*	54.40*
THIS PROVIDER YEAR-TO-DATE				175.80	72.80	3	3	58.60	58.60
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
OCEAN	250838691		UNKN	15.95	15.95	1	1	15.95*	15.95*
THIS PROVIDER YEAR-TO-DATE				15.95	15.95	1	1	15.95	15.95
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
PASSAIC	221147990		UNKN	49.95	49.95	1	1	49.95*	49.95*
THIS PROVIDER YEAR-TO-DATE				49.95	49.95	1	1	49.95	49.95
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
PASSAIC	221408462		UNKN	53.60	53.60	2	2	26.80*	26.80*
THIS PROVIDER YEAR-TO-DATE				60.55	60.55	3	3	20.18	20.18
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
PASSAIC	221424783		UNKN	48.86	48.86	3	3	16.28*	16.28*
THIS PROVIDER YEAR-TO-DATE				128.02	128.02	8	8	16.00	16.00
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
PASSAIC	221448260		UNKN	12.95	12.95	1	1	12.95*	12.95*
THIS PROVIDER YEAR-TO-DATE				12.95	12.95	1	1	12.95	12.95
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
PASSAIC	221662314		UNKN	36.75	36.75	2	2	18.37*	18.37*
THIS PROVIDER YEAR-TO-DATE				99.50	99.50	6	6	16.58	16.58
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
PASSAIC	221687361		UNKN	395.50	395.50	3	3	131.83*	131.83*

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT PS22

FEBRUARY 1971

PROSTHETIC DEVICES

SPECIAL SERVICES SURVEILLANCE REPORT

COUNTY	PROVIDER NUMBER	PROVIDER NAME	SPLTY	---ALL RECIPIENTS---- TOT CHARGE	PAYMENTS	----NUMBER OF--- RECIPIENT	CLAIMS	---CHARGE PER- RECIPNT	CLAIM
SELECTION CRITERIA				G $400	G $400	G 10	10	G $40	G $40
THIS PROVIDER YEAR-TO-DATE				3855.35	3853.35	15	15	257.02	257.02
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	003202601		UNKN	1001.05 *	1001.05 *	5	5	200.21*	200.21*
THIS PROVIDER YEAR-TO-DATE				3284.00	3284.00	15	15	218.93	218.93
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	071207775		UNKN	316.00	316.00	1	1	316.00*	316.00*
THIS PROVIDER YEAR-TO-DATE				640.75	640.75	4	4	160.19	160.19
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	138094631		UNKN	295.20	295.20	1	1	295.20*	295.20*
THIS PROVIDER YEAR-TO-DATE				295.20	295.20	1	1	295.20	295.20
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	154267479		UNKN	85.00	85.00	1	1	85.00*	85.00*
THIS PROVIDER YEAR-TO-DATE				112.95	112.95	2	2	56.48	56.48
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221430704		UNKN	249.00	249.00	5	5	49.80*	49.80*
THIS PROVIDER YEAR-TO-DATE				1575.00	1575.00	14	14	112.50	112.50
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221542828		UNKN	3632.40 *	3619.90 *	65*	67*	55.88*	54.21*
THIS PROVIDER YEAR-TO-DATE				6921.10	6870.60	142	148	48.74	46.76
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221616014		UNKN	145.00	145.00	1	1	145.00*	145.00*
THIS PROVIDER YEAR-TO-DATE				145.00	145.00	1	1	145.00	145.00
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221619941		UNKN	349.49	349.49	17*	17*	20.55	20.55
THIS PROVIDER YEAR-TO-DATE				581.53	576.24	29	29	20.05	20.05
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221639242		UNKN	783.50 *	783.50 *	4	4	195.87*	195.87*
THIS PROVIDER YEAR-TO-DATE				1858.50	1858.50	16	16	116.16	116.16
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221668600		UNKN	103.50	103.50	1	1	103.50*	103.50*
THIS PROVIDER YEAR-TO-DATE				799.50	799.50	5	11	159.90	72.68
THIS PROVIDER PRIOR YEAR				.00	.00			.00	.00
ESSEX	221711862		UNKN	996.60 *	996.60 *	17*	17*	58.62*	58.62*
THIS PROVIDER YEAR-TO-DATE				3360.56	3360.56	50	52	67.21	64.63
THIS PROVIDER PRIOR YEAR				.00	.00			.00	
ESSEX	221718602		AN	703.70 *	689.70 *	6	6	117.28*	117.28*

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT PS24
FEBRUARY 1971

ESSEX COUNTY — RECIPIENT SURVEILLANCE REPORT — PAGE 193

RECIPIENT NUMBER / RECIPIENT NAME	AGE	SEX	STATUS CODE	P N	INPATIENT MEDICAID PAYMENT	PRACT NURS VISIT	AND OUTP- MEDICAID PAYMENTS	NURSE HOME PAYMT	DRUGS NUM RX	DRUGS MEDICAID PAYMENTS	H.H. PAY- MENTS	OTHER PAY- MENTS	TOTAL PAY- MENTS
SELECTION CRITERIA				G	$700 G	10 G	$125 G	$540 G	15 G	$55 G	$75 G	$50 G	$800
073000314220	17	F	31		0	26 *	304 *	0	0	0	0	0	304
THIS RECIPIENT YEAR-TO-DATE					2176	27	339	0	3	7	0	0	2523
THIS RECIPIENT PRIOR YEAR					0	4	54	0	0	0	0	0	54
073000320201	34	F	31		0	0	299 *	0	0	0	0	0	299
THIS RECIPIENT YEAR-TO-DATE					0	2	311	0	1	3	0	0	314
THIS RECIPIENT PRIOR YEAR					0	3	21	0	1	3	0	47	71
073000323820	17	F	31		0	11 *	110	0	0	0	0	0	110
THIS RECIPIENT YEAR-TO-DATE					0	11	110	0	0	0	0	0	110
THIS RECIPIENT PRIOR YEAR					0	3	108	0	4	17	0	0	125
073000330301	71	F	31		816 *	1	235 *	0	1	3	0	0	1054 *
THIS RECIPIENT YEAR-TO-DATE					816	2	659	0	1	3	0	0	1478
THIS RECIPIENT PRIOR YEAR					0	4	51	0	20	71	0	0	122
073000335321	12	M	31		0	42 *	400 *	0	0	0	0	0	400
THIS RECIPIENT YEAR-TO-DATE					0	88	689	0	0	0	0	0	689
THIS RECIPIENT PRIOR YEAR					3712	7	250	0	1	1	0	53	4017
073000338401	42	F	31		0	3	196 *	0	5	15	0	0	211
THIS RECIPIENT YEAR-TO-DATE					0	4	206	0	14	48	0	0	254
THIS RECIPIENT PRIOR YEAR					0	11	341	0	13	61	0	45	447
073000343701	47	F	31		0	0	0	0	34 *	118 *	0	0	118
THIS RECIPIENT YEAR-TO-DATE					0	0	0	0	43	151	0	0	151
THIS RECIPIENT PRIOR YEAR					0	0	0	0	0	0	0	0	0
073000343801	34	F	31		1292 *	2	585 *	0	3	10	0	0	1888 *
THIS RECIPIENT YEAR-TO-DATE					1292	3	600	0	9	40	0	0	1933
THIS RECIPIENT PRIOR YEAR					421	22	489	0	20	101	0	0	1012
073000345920	16	F	31		1767 *	0	0	0	0	0	0	0	1767 *
THIS RECIPIENT YEAR-TO-DATE					2736	2	40	0	0	0	0	27	2803
THIS RECIPIENT PRIOR YEAR					562	48	464	0	73	324	0	5	1355
073000348401	45	F	31		1296 *	1	13	0	0	0	0	0	1309 *
THIS RECIPIENT YEAR-TO-DATE					1296	2	26	0	12	37	0	0	1359
THIS RECIPIENT PRIOR YEAR					0	33	554	0	67	226	0	23	803
073000352301	36	F	31		0	9	154 *	0	0	0	0	0	154
THIS RECIPIENT YEAR-TO-DATE					0	16	358	0	0	0	0	0	358
THIS RECIPIENT PRIOR YEAR					652	11	332	0	2	7	0	0	992
073000356202	45	F	44		342	2	245 *	0	0	0	0	0	588
THIS RECIPIENT YEAR-TO-DATE					342	2	245	0	0	0	0	27	615
S RECIPIENT PRIOR YEAR						3	43	0	3	12	0	24	80

Exhibit V-14

STATE OF [illegible]
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

[illegible] COUNTY

INPATIENT HOSPITAL DETAIL REPORT

[illegible]

PROVIDER NUMBER	RECIPIENT NUMBER	# ATTENDING PRACTITIONER	ADJ CODE	CLAIM NUMBER	RECIPIENT AGE	SEX	ADMISSION DATE	DISCHARGE DATE	PRIMARY DIAG	PRIMARY PROC	EXCESS AID DAYS	DSCH STAT	[illegible] IS CLAIM [illegible] CHARGES	[illegible] PAYMENT
0371[illegible]07	07[illegible]2			0015000579	09	F	02-10-71	02-12-71	5000	29020	000	2	218.50	[illegible]
[illegible]	[illegible]			0016000378	06	F	02-10-71	02-12-71	5000	29020	000	2	217.00	[illegible]
[illegible]	[illegible]			0040[illegible]005	34	M	01-26-71	01-27-71	5810	00000	000	2	105.00	[illegible]
[illegible]	[illegible]			0042[illegible]003	07	F	01-21-71	01-22-71	5000	00000	000	2	[illegible]	[illegible]
[illegible]07	[illegible]			0042100074	07	M	09-30-70	10-02-70	5110	29120	000	2	[illegible]	[illegible]
[illegible]	[illegible]			0043100075	03	F	09-30-70	10-02-70	5000	29120	000	2	[illegible]	[illegible]
[illegible]	[illegible]			0044[illegible]006	06	F	02-18-71	02-20-71	5000	29020	000	2	[illegible]	[illegible]
[illegible]	[illegible]			0045[illegible]005	04	M	02-18-71	02-20-71	5000	29020	000	2	[illegible]	[illegible]
[illegible]	[illegible]			0046[illegible]009	71	F	01-26-71	01-31-71	5180	45810	002	2	[illegible]	[illegible]
[illegible]	[illegible]			0047[illegible]54	04	F	02-03-71	02-05-71	5000	29020	000	2	[illegible]	[illegible]
[illegible]	[illegible]			0048[illegible]591	51	M	02-05-71	02-16-71	5110	00000	000	2	[illegible]	[illegible]
[illegible]	[illegible]			0048[illegible]003	09	M	02-16-71	02-18-71	5000	29020	000	2	[illegible]	[illegible]
[illegible]	[illegible]			0049[illegible]077	03	F	02-11-71	02-13-71	5000	29020	000	2	[illegible]	[illegible]
[illegible]	[illegible]			0047[illegible]490	35	F	02-05-71	02-10-71	6440	45810	001	2	[illegible]	[illegible]
[illegible]	[illegible]			0048[illegible]780	45	F	02-03-71	02-11-71	6220	45760	000	2	[illegible]	[illegible]
[illegible]	[illegible]			0049[illegible]602	17	F	02-05-71	02-09-71	5520	00000	000	2	[illegible]	[illegible]
[illegible]	[illegible]			0048[illegible]912	80	F	01-05-71	01-11-71	4120	00000	000	2	[illegible]	[illegible]
[illegible]	[illegible]										THIS MONTH	-	11[illegible].15	[illegible]
0[illegible]001	07[illegible]401			0042700785	23	M	08-24-70	09-02-70	3440	00000	000	2	714.90	[illegible]
											THIS MONTH	-	714.90	[illegible]
[illegible]	[illegible]			7105[illegible]531	06	M	01-18-71	01-18-71	5810	59510	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7102[illegible]175	82	F	00-00-00	00-00-00	7250	00000	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7104[illegible]026	15	M	07-12-70	00-00-00	5990	00000	000	1	15[illegible]	[illegible]
[illegible]	[illegible]			7103[illegible]036	05	F	01-18-71	01-22-71	7[illegible]	00000	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7104[illegible]003	31	F	01-23-71	01-24-71	6[illegible]	44100	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7104[illegible]008	01	M	01-23-71	01-25-71	5[illegible]	00000	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7103[illegible]005	71	F	01-25-71	02-03-71	5810	00000	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7104[illegible]0	15	F	01-25-71	01-29-71	5000	29120	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7104[illegible]0	32	F	01-19-71	01-23-71	5[illegible]	[illegible]10	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7103[illegible]1	07	F	01-24-71	01-27-71	7[illegible]	00000	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7101[illegible]	39	F	01-14-71	01-18-71	5810	00000	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7102[illegible]14	66	F	12-10-70	12-14-70	5[illegible]0	00000	000	2	[illegible]	[illegible]
[illegible]	[illegible]			[illegible]	[illegible]	F	10-07-70	10-10-70	[illegible]	00000	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7103[illegible]0	37	F	01-18-71	01-22-71	[illegible]	[illegible]810	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7104[illegible]0	80	F	01-01-71	01-10-71	[illegible]	[illegible]	002	2	[illegible]	[illegible]
[illegible]	[illegible]			7104[illegible]0	80	F	01-13-71	01-14-71	[illegible]	[illegible]	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7[illegible]	21	F	01-[illegible]-71	02-01-71	5110	[illegible]	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7[illegible]	01	F	01-[illegible]-71	[illegible]-[illegible]-71	[illegible]	[illegible]	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7[illegible]	05	F	01-[illegible]-71	01-[illegible]-71	[illegible]	[illegible]	000	2	[illegible]	[illegible]
[illegible]	[illegible]			7[illegible]	52	F	01-[illegible]-71	01-[illegible]-71	[illegible]	[illegible]	1	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]-[illegible]-70	01-[illegible]-71	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]			[illegible]	44	[illegible]	12-11-70	[illegible]-[illegible]-[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	12-[illegible]-70	[illegible]-[illegible]-[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	1[illegible]-[illegible]-70	12-[illegible]-70	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]-[illegible]-[illegible]	01-[illegible]-71	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]			[illegible]	11	[illegible]	12-[illegible]-70	01-[illegible]-70	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
											THIS MONTH	-	[illegible]	[illegible]

STATE OF [illegible]
DIVISION OF [illegible] AND SERVICES
[illegible]

[illegible] HOSPITAL DETAIL REPORT

[illegible]

PATIENT ACCOUNT NUMBER	RECIPIENT NUMBER	REFERRING PRACTITIONER	ADJ CODE	CLAIM NUMBER	RECIPIENT AGE	SEX	DATE OF FIRST SERVICE	DATE OF LAST SERVICE	# VISITS IN PERIOD	DEPT-CLIN DESC	PROCEDURE	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	11	F	01-12-71	01-12-71	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	10	M	12-18-70	12-23-70	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	03	F	01-28-71	01-28-71	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	55	F	01-03-71	01-03-71	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	18	M	12-23-70	12-23-70	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	10	M	01-06-71	01-06-71	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	11	F	12-15-70	12-15-70	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	06	F	11-25-70	11-25-70	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	51	F	12-08-70	12-08-70	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	45	F	01-18-71	01-18-71	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	01	M	12-15-70	12-15-70	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	55	M	02-03-71	02-03-71	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	01	M	01-03-71	01-03-70	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	57	M	01-03-71	01-03-71	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	59	M	01-03-71	01-03-71	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	11	F	10-03-70	10-03-70	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	57	F	02-01-71	02-01-71	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	70	F	01-29-71	01-29-71	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	23	F	01-26-71	01-26-71	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	20	F	01-19-71	01-19-71	01	[illegible]	[illegible]	[illegible]	[illegible]
YTD CHARGES -				2331.70			YTD PAYMENTS -		2331.70				
[illegible]	[illegible]	[illegible]	A	[illegible]	[illegible]	F	[illegible]	[illegible]	01	FAC	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	A	[illegible]	[illegible]	F	[illegible]	[illegible]	01	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

STATE OF [illegible]
DEPARTMENT OF [illegible] AND HYGIENE
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

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PROVIDER NUMBER	RECIPIENT NUMBER	REFERRING PRACTITIONER	ADJ CODE	CLAIM NUMBER	RECIPIENT AGE	SEX	DATE OF SERVICE FROM	DATE OF SERVICE TO	# VISITS IN PERIOD	DEPT-CLIN DESC	PRIMARY DIAGNOSIS	THIS CLAIM TOTAL CHARGES	THIS CLAIM ALLOWED PAYMENTS
[illegible]	[illegible]			710[illegible]3	05	F	01-20-71	01-26-71	01	CLINIC	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	01-20-71	01-20-71	01	CLINIC	[illegible]	5.00	5.00
[illegible]	[illegible]			[illegible]	71	[illegible]	01-18-71	01-18-71	01	CLINIC	[illegible]	5.00	5.00
[illegible]	[illegible]			710[illegible]2	[illegible]	[illegible]	01-20-71	01-26-71	01	CLINIC	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	12-14-70	12-14-70	01	[illegible]	[illegible]	7.00	7.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	11-[illegible]-70	11-[illegible]-70	01	[illegible]	[illegible]	20.00	20.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	01-19-71	01-19-71	01	[illegible]	[illegible]	5.00	5.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	02-02-71	02-02-71	01	CLINIC	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	01-19-71	01-19-71	01	CLINIC	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	01-20-71	01-26-71	01	CLINIC	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	02-02-71	02-02-71	01	CLINIC	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	01-19-71	01-19-71	01	[illegible]	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	01-19-71	01-19-71	01	[illegible]	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	02-02-71	02-02-71	01	[illegible]	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	01-20-71	01-26-71	01	[illegible]	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	02-02-71	02-02-71	01	[illegible]	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	01-22-71	01-22-71	01	[illegible]	[illegible]	5.00	5.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	01-19-71	01-19-71	01	[illegible]	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	01-26-71	01-26-71	01	[illegible]	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	02-02-71	02-02-71	01	[illegible]	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	15	[illegible]	02-02-71	02-02-71	01	[illegible]	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	12	[illegible]	02-02-71	02-02-71	01	[illegible]	[illegible]	10.00	10.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	01-22-71	01-22-71	01	[illegible]	[illegible]	5.00	5.00
YTD CHARGES - 2065.00				YTD PAYMENTS - 2058.00						THIS MONTH -		220.00	220.00
[illegible]	[illegible]			710[illegible]71	17	F	12-15-70	12-15-70	01	CLINIC	[illegible]	7.00	7.00
[illegible]	[illegible]			[illegible]	13	[illegible]	12-17-70	12-17-70	03	[illegible]	[illegible]	50.00	50.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	12-02-70	12-07-70	02	[illegible]	[illegible]	14.00	14.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	12-10-70	12-10-70	01	[illegible]	[illegible]	7.00	7.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]			[illegible]	02	[illegible]	11-09-70	11-09-70	01	[illegible]	[illegible]	7.00	7.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	11-[illegible]-70	11-17-70	02	[illegible]	[illegible]	14.00	14.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	11-[illegible]-70	11-[illegible]-70	02	[illegible]	[illegible]	14.00	14.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	11-[illegible]-70	11-[illegible]-70	01	[illegible]	[illegible]	7.00	7.00
[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	11-[illegible]-70	11-[illegible]-70	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

DIVISION OF [illegible]

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PROVIDER NUMBER	RECIPIENT NUMBER	REFERRING PRACTITIONER	ADJ CODE	CLAIM NUMBER	RECIPIENT AGE	SEX	DATE OF SERVICE FROM	TO	# VISITS IN PERIOD	PLACE OF SERVICE	PRIMARY DIAG	PROC	THIS CLAIM TOTAL CHARGES	THIS CLAIM RECEIVED PAYMENT
[illegible]	[illegible]			710[illegible]	52	F	10-26-70	10-26-70	01	11	7150	11403	750.00	371.00
[illegible]	[illegible]			710[illegible]	52	F	02-02-71	02-02-71	01	04	7850	00010	10.00	8.00
[illegible]	[illegible]	YTD CHARGES -		5184.00			YTD PAYMENTS -		1689.83		THIS MONTH -		2445.00	1120.00
[illegible]	[illegible]			710[illegible]	60	F	10-16-70	10-27-70	01	11	7100	99213		
[illegible]	[illegible]			710[illegible]	[illegible]	[illegible]	10-15-70	10-27-70	03	11	7150	00010	80.00	60.00
[illegible]	[illegible]			710[illegible]	[illegible]	[illegible]	10-14-70	10-[illegible]-70	01	11	7[illegible]	[illegible]		
[illegible]	[illegible]			710[illegible]	[illegible]	[illegible]	10-14-70	10-[illegible]-70	01	11	7[illegible]	[illegible]	550.00	353.00
[illegible]	[illegible]			710[illegible]	[illegible]	[illegible]	09-21-70	09-[illegible]-70	01	11	7[illegible]	[illegible]		
[illegible]	[illegible]			710[illegible]	[illegible]	[illegible]	09-21-70	09-18-70	01	11	7[illegible]	[illegible]	545.00	341.00
[illegible]	[illegible]			710[illegible]	[illegible]	[illegible]	09-[illegible]-70	09-11-70	01	11	[illegible]	[illegible]	

PATIENT NUMBER	RECORD NUMBER	PATIENTS NAME RECIPIENT NAME	ADJ CODE	CLAIM NUMBER	RECIPIENT AGE SEX	DATE OF FIRST SERVICE	DATE OF LAST SERVICE	# VISITS IN PERIOD	PLACE OF SERVICE	PENALTY DAYS - PRIOR	TOTAL CHARGES	TOTAL CHARGES PAID
											9.00	4.50
											4.00	2.00
											3.00	1.50
											16.00	8.00
											18.00	9.00
											24.00	12.00
											6.00	3.00
											4.00	2.00
											6.00	3.00
											4.00	2.00

PATIENT NAME	PATIENT ACCT NO	PERSONS PRACTITIONER	ADJ CODE	CLAIM NO	AGE	SEX	DATE(S) OF SERVICE	PLACE OF SERVICE	TYPE OF SERVICE	CHARGES	PAYMENTS	BALANCE

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

DENTISTS DETAIL REPORT

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PROVIDER NUMBER	RECIPIENT NUMBER	REFERRING PRACTITIONER	ADJ CODE	CLAIM NUMBER	RECIPIENT AGE	SEX	DATE OF SERVICE FROM	TO	# VISITS IN PERIOD	PLACE OF SERVICE	PRIMARY DIAG - PROC	THIS CLAIM TOTAL CHARGES	THIS CLAIM MEDICAID PAYMENT
				7104961079	28	F	11-10-70	12-15-70		0FFI		179.00	179.00
				YTD CHARGES - 2117.00			YTD PAYMENTS - 2117.00				THIS MONTH -	255.00	255.00
				7103550220	03	F	07-27-70	10-16-70		0FFI		135.00	135.00
				YTD CHARGES - 162.00			YTD PAYMENTS - 162.00				THIS MONTH -	135.00	135.00
				7103550215	24	F	08-02-70	08-20-70		0FFI		227.00	227.00
				7104550072	24	M	10-17-70	12-02-70		0FFI		155.00	155.00
				7104550075	24	M	02-08-71	02-08-71		0FFI		305.00	305.00
				YTD CHARGES - 4231.00			YTD PAYMENTS - 4231.00				THIS MONTH -	687.00	687.00
				7104901854	55	F	07-30-70	11-30-70		0FFI		433.00	433.00
				7103551550	09	F	10-17-70	11-25-70		0FFI		47.00	47.00
				7103551557	09	F	01-23-71	01-25-71		0FFI		16.00	16.00
				7104900431	34	M	05-16-70	05-16-70		0FFI		17.00	17.00
				7103951423	28	F	05-25-70	11-20-70		0FFI		342.00	342.00
				YTD CHARGES - 1621.00			YTD PAYMENTS - 1621.00				THIS MONTH -	855.00	855.00
				7104900017	19	M	02-02-71	02-02-71		0FFI		9.00	9.00
				7103550025	15	M	01-04-71	01-05-71		0FFI		63.00	63.00
				7103550033	41	F	01-11-71	01-11-71		0FFI		10.00	10.00
				7104550038	10	M	01-04-71	01-25-71		0FFI		25.00	25.00
				7104950029	26	F	01-29-71	01-29-71		0FFI		9.00	9.00
				7105550121	04	F	10-21-70	11-25-70		0FFI		35.00	35.00
				YTD CHARGES - 1724.00			YTD PAYMENTS - 1724.00				THIS MONTH -	150.00	150.00
				7104550036	14	M	01-22-71	01-22-71		0FFI		31.00	31.00
				7104900920	07	F	01-28-71	01-28-71		0FFI		21.00	21.00
				7104550039	35	F	12-02-70	12-02-70		0FFI		2.00	2.00
				7104550040	35	F	01-15-71	01-15-71		0FFI		53.00	53.00
				7103550050	07	M	11-20-70	11-20-70		0FFI		2.00	2.00
				7104550070	07	M	01-09-71	01-09-71		0FFI		40.00	40.00
				7104550073	25	M	01-04-71	01-07-71		0FFI		80.00	80.00
				7104550078	28	M	07-09-70	07-09-70		0FFI		12.00	12.00
				7104	39	F	11-19-70	11-19-70		0FFI		11.00	11.00
				7104	39	F	02-01-71	02-01-71		0FFI		6.00	6.00
				7104	17	M	10-19-70	10-19-70		0FFI		50.00	50.00
				7103	04	M	01-18-71	01-18-71		0FFI		11.00	11.00
				7104951515	05	F	01-20-71	01-20-71		0FFI		11.00	11.00
				7103	10	M	12-08-70	12-08-70		0FFI		11.00	11.00
				YTD CHARGES -			YTD PAYMENTS - 502.00				THIS MONTH -	354.00	354.00
				7104	24	F	09-04-70	10-06-70		0FFI		529.00	529.00
				7104	29	F	12-07-70	12-07-70		0FFI		21.00	21.00
				7103	27	F	01-11-71	02-03-71		0FFI		179.00	179.00
				YTD CHARGES - 729.00			YTD PAYMENTS - 729.00				THIS MONTH -	729.00	729.00
				7104	59	F	10-10-70	12-10-70		0FFI		17.00	17.00
				7104	16	M	01-14-71	01-14-71		0FFI		9.00	9.00

Exhibit V-17

DIVISION OF [illegible] AND HUMAN SERVICES

BASIS SERIAL REPORT

PATIENT ID	PATIENT NUMBER	FINGERPRINT NUMBER	ADJ CODE	BATCH NUMBER	CLAIM NUMBER	AGE	SEX	DATE DISPOSED	FBI NUMBER	BASIS CODE	BASIS NOTE	CRT DIS CD	DAY DIS CD	RT LD FC	PAT CLASS
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	55	M	01-23-71	419415	[illegible]	[illegible]	003	034	0 2	2
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	61	M	01-23-71	419415	[illegible]	[illegible]	003	010	0 2	2
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	61	M	01-23-71	419415	[illegible]	[illegible]	[illegible]	[illegible]	0 2	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	55

Exhibit V-18

STATE OF [illegible]
DEPARTMENT OF [illegible] AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

[illegible]

RURAL HEALTH AGENCIES DETAIL REPORT

PAGE 33

PATIENT NAME	PATIENT NUMBER	ATTENDING PRACT #	ADJ CODE	CLAIM NUMBER	AGE	SEX	DATE OF SERVICE FROM	DATE OF SERVICE TO	NUMBER VISITS	PRIM DIAG	PRIMARY SERVICE DESCRIPTION	CHRG CODE	CHARGE AMT
[illegible]	[illegible]			[illegible]	43	F	01-14-71	01-25-71	07	[illegible]	[illegible]	[illegible]	[illegible]
				[illegible]	[illegible]	F	01-12-71	01-20-71	[illegible]				
				[illegible]			01-07-71	01-18-71					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			12-20-70	12-21-70					
				[illegible]			01-10-71	01-10-71					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			01-20-71	01-20-71					
				[illegible]	65	F	01-07-71	01-21-71	04				
-		YTD CHARGES -		870.25			YTD PAYMENTS -	650.25		THIS MONTH -		570.25	
[illegible]	[illegible]			[illegible]	58	M	10-01-70	10-28-70	18	[illegible]	[illegible]	[illegible]	[illegible]
				[illegible]	57		[illegible]	12-21-70	10				
				[illegible]	61	F	12-[illegible]-70	12-[illegible]-70	11				
		YTD CHARGES -		1012.62			YTD PAYMENTS -	1012.62		THIS MONTH -		[illegible]	
	[illegible]			[illegible]	64	F	12-30-70	01-04-71	10				
		YTD CHARGES -		203.70			YTD PAYMENTS -	203.70		THIS MONTH -		203.70	
[illegible]	[illegible]			[illegible]	68	M	01-04-71	01-27-71					
				[illegible]			11-21-70	11-[illegible]-70					
				[illegible]			11-27-70	11-30-70					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			[illegible]	[illegible]					
				[illegible]			01-01-71	01-20-71					
				[illegible]	31	M	12-11-70	12-30-70	04				
-		YTD CHARGES -		1435.40			YTD PAYMENTS -	1035.15		THIS MONTH -		1032.15	

REQUIRED DATA ELEMENT
PATIENT CODE
PROVIDER COUNTY
PROVIDER NUMBER
RECIPIENT NUMBER

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

SKILLED NURSING HOME DETAIL REPORT

REPORT XXXX
MONTH 19 XX
PAGE XXXX

	1	2	3	4	5	6	7	8	9	10
	PROVIDER COUNTY (OR STATE) DESCRIPTION	PROVIDER NUMBER	RECIPIENT NUMBER	ATTENDING PRACTITIONER NUMBER	ADJUSTMENT CODE	CLAIM NUMBER	RECIPIENT AGE	RECIPIENT SEX	DATE OF ADMISSION	DATE OF DISCHARGE
DATA ELEMENT NUMBER	301	203	204	218	219	205	215	216	226	227

FOR EACH PROVIDER

	11	12	13	14						
	PRIMARY DIAGNOSIS CODE	DISCHARGE STATUS CODE	TOTAL CHARGES THIS CLAIM	MEDICAID PAYMENT THIS CLAIM						
DATA ELEMENT NUMBER	224	223	214	212						

SUM

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STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT PGM3

MEDICAL AFFILIATES — SPECIAL SERVICES DETAIL REPORT — PAGE 37

PROVIDER COUNTY	PROVIDER NUMBER	RECIPIENT NUMBER	REFERRING PRACTITIONER #	ADJUST CODE	CLAIM NUMBER	RECIPIENT AGE	RECIPIENT SEX	DATE OF SERVICE	PLACE	THIS CLAIM TOT CHARGE	THIS CLAIM PAYMT
[illegible]	[illegible]	[illegible]			[illegible]	12	M	12-17-70	10		
[illegible]	[illegible]	[illegible]			[illegible]	11	M	12-17-70	10		
[illegible]	[illegible]	[illegible]			[illegible]	11	M	12-17-70	10	20.30	20.30
[illegible]	[illegible]	[illegible]			[illegible]	11	M	12-17-70	10		
[illegible]	[illegible]	[illegible]			[illegible]	11	M	12-17-70	10	21.65	21.65
[illegible]	[illegible]	[illegible]			[illegible]	11	M	12-11-70	10		
[illegible]	[illegible]	[illegible]			[illegible]	11	M	12-11-70	10	20.85	20.85
[illegible]	[illegible]	[illegible]			[illegible]	11	M	12-21-70	10		
[illegible]	[illegible]	[illegible]			[illegible]	11	M	12-21-70	10	19.50	19.50
[illegible]	[illegible]	[illegible]			[illegible]	14	M	12-11-70	10		
[illegible]	[illegible]	[illegible]			[illegible]	14	M	12-11-70	10	21.45	21.45
[illegible]	[illegible]	[illegible]			[illegible]	11	M	[illegible]	10		
[illegible]	[illegible]	[illegible]			[illegible]	11	M	[illegible]	10	20.30	20.30
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	25.50	21.50
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	20.30	20.30
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]	10	20.70	[illegible]
[illegible]	YTD CHARGES =		731.65	YTD PAYMENTS =	709.[illegible]			[illegible]		280.40	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	01-11-71	[illegible]		
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	01-11-71	[illegible]		
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	01-11-71	10		
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	01-11-71	[illegible]		
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	01-11-71	[illegible]	20.15	[illegible]
[illegible]	YTD CHARGES =		[illegible]	YTD PAYMENTS =	[illegible]			[illegible]		22.10	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	M	[illegible]	[illegible]		
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		

STATE OF [illegible]
DEPARTMENT OF [illegible]
DIVISION OF [illegible] SERVICES
MEDICAL ASSISTANCE MENTAL HEALTH SERVICES

SPECIAL SERVICES DETAIL REPORT

PROVIDER NUMBER	RECIPIENT NUMBER	REFERRING PRACTITIONER #	ADJUST CODE	CLAIM NUMBER	RECIPIENT AGE	RECIPIENT SEX	DATE OF SERVICE	FAMILY PLAN	TYPE OF SERVICE	UNITS	AMOUNT
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	05	M	01-03-71	[illegible]	[illegible]	7.00	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	50	[illegible]	01-03-71	[illegible]	[illegible]	17.00	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	21	[illegible]	01-03-71	[illegible]	[illegible]	22.00	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	01-03-71	[illegible]	[illegible]	22.00	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	01-03-71	[illegible]	[illegible]	15.00	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	01-03-71	[illegible]	[illegible]	7.00	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	01-03-71	[illegible]	[illegible]	12.00	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	01-03-71	[illegible]	[illegible]	12.00	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	01-03-71	[illegible]	[illegible]	7.00	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	01-03-71	[illegible]	[illegible]	15.00	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	01-03-71	[illegible]	[illegible]	15.00	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

STATE OF [illegible]
DEPARTMENT OF [illegible] AND AGENCIES
DIVISION OF [illegible] AND HEALTH SERVICES

SOCIAL SERVICES DETAIL REPORT

RECIPIENT COUNTY	PROVIDER NUMBER	RECIPIENT NUMBER	REFERRING PRACTITIONER #	ADJUST CODE	CLAIM NUMBER	RECIPIENT AGE	SEX	DATE OF SERVICE	FROM PAID	THIS CLAIM TOT CHARGE	THIS CLAIM PAID
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	M	12-08-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	M	03-21-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	12-21-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	12-21-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	03-03-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	11-20-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	M	12-11-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	M	12-10-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	M	01-15-71		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	01-15-71		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	M	03-16-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	M	03-16-70		[illegible]	[illegible]
[illegible]	YTD CHARGES -		491.20	YTD PAYMENTS -		405.20		THIS MONTH -		280.20	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	07-27-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	08-[illegible]-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	11-19-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	03-03-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	08-17-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	08-27-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	10-07-70		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	M	12-01-70		[illegible]	[illegible]
[illegible]	YTD CHARGES -		1354.20	YTD PAYMENTS -		1031.40		THIS MONTH -		163.00	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	11-17-70		[illegible]	
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	11-[illegible]-70		[illegible]	4.40
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	11-[illegible]-70		[illegible]

STATE OF [illegible]
DEPARTMENT OF [illegible] AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

SPECIAL SERVICES DETAIL REPORT

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PROVIDER COUNTY	PROVIDER NUMBER	RECIPIENT NUMBER	REFERRING PRACTITIONER #	ADJUST CODE	CLAIM NUMBER	RECIPIENT AGE	SEX	DATE OF SERVICE	PROC	THIS CLAIM TOT CHARGE	PAYMT
[illegible]		YTD CHARGES -	951.05		YTD PAYMENTS -	951.05		THIS MONTH -		720.00	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	16	F	01-20-71	780	[illegible]	[illegible]
					[illegible]	01	F	01-29-71	[illegible]	12.00	[illegible]
					[illegible]	01	M	01-07-71	[illegible]	[illegible]	[illegible]
					[illegible]	32	F	01-13-71	[illegible]	[illegible]	[illegible]
					[illegible]	32	F	01-27-71	[illegible]	[illegible]	[illegible]
					[illegible]	00	F	01-19-71	[illegible]	[illegible]	[illegible]
					[illegible]	00	F	01-20-71	[illegible]	[illegible]	[illegible]
					[illegible]	00	F	01-15-71	[illegible]	[illegible]	[illegible]
					[illegible]	00	M	01-29-71	[illegible]	[illegible]	[illegible]
					[illegible]	00	M	02-02-71	[illegible]	[illegible]	[illegible]
					[illegible]	41	F	01-26-71	[illegible]	[illegible]	[illegible]
					[illegible]	00	M	11-09-70	[illegible]	[illegible]	[illegible]
					[illegible]	25	F	02-12-71	[illegible]	[illegible]	[illegible]
[illegible]		YTD CHARGES -	192.33		YTD PAYMENTS -	192.33		THIS MONTH -		83.00	83.00
[illegible]	[illegible]	[illegible]			[illegible]	05	F	12-23-70	1010	8.33	7.50
[illegible] DRUGS INC		YTD CHARGES -	8.33		YTD PAYMENTS -	7.50		THIS MONTH -		8.33	7.50
[illegible]	[illegible]	[illegible]			[illegible]	72	M	12-27-70		[illegible]	[illegible]
					[illegible]	[illegible]	M	[illegible]		[illegible]	[illegible]
					[illegible]	[illegible]	M	[illegible]		[illegible]	[illegible]
					[illegible]	[illegible]	F	[illegible]		[illegible]	[illegible]
					[illegible]	[illegible]	F	[illegible]	[illegible]	[illegible]	[illegible]
					[illegible]	[illegible]	F	[illegible]		[illegible]	[illegible]
					[illegible]	[illegible]	M	[illegible]		[illegible]	[illegible]
					[illegible]	[illegible]	M	[illegible]		[illegible]	[illegible]
					[illegible]	[illegible]	M	[illegible]		[illegible]	[illegible]
					[illegible]	[illegible]	M	[illegible]		[illegible]	[illegible]
					[illegible]	[illegible]	M	[illegible]		[illegible]	[illegible]
					[illegible]	[illegible]	F	[illegible]		[illegible]	[illegible]
[illegible]		YTD CHARGES -	[illegible]		YTD PAYMENTS -	[illegible]		THIS MONTH -		[illegible]	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	[illegible]	[illegible]	[illegible]	[illegible]
			[illegible]		YTD PAYMENTS -	[illegible]		THIS MONTH -		15.00	[illegible]
[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	F	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]		YTD CHARGES -	[illegible]		YTD PAYMENTS -	[illegible]		THIS MONTH -		1.00	[illegible]

Exhibit V-200
Page 5 of 5

DIVISION OF [illegible] AND HEALTH SERVICES

SPECIAL SERVICES MEDICAL UNIT

FEBRUARY 1971

PAGE 103

PROVIDER NUMBER	RECIPIENT NUMBER	REFERRING PRACTITIONER #	ADJUST CODE	CLAIM NUMBER	RECIPIENT AGE	RECIPIENT SEX	DATE OF SERVICE	PROC	THIS CLAIM TOT CHARGE	THIS CLAIM PAYMT
[illegible]	[illegible]			[illegible]	03	M	02-10-71	9910	12.50	10.00
					03	F	02-10-71	9910	18.50	16.15
					04	M	01-26-71	9911	29.50	23.15
					06	M	01-18-71	9910		
					03	M	01-18-71	9870	50.00	51.00
[illegible]	YTD CHARGES -	242.65		YTD PAYMENTS -	242.65		THIS MONTH -		107.15	107.15
[illegible]	[illegible]			[illegible]	28	F	01-20-71	9910	60.00	51.00
					57	F	01-18-71	9910	150.00	150.00
					06	M	01-20-70	9977	70.00	70.00
					03	F	02-03-71	9700	100.00	100.00
					15	M	01-26-71	4215	50.00	50.00
[illegible]	YTD CHARGES -	1575.00		YTD PAYMENTS -	1575.00		THIS MONTH -		240.00	271.00
[illegible]	[illegible]			[illegible]	72	F	11-12-70		2.50	2.50
					70	M	11-12-70		10.00	
					36	F	01-20-71	9910	50.00	50.00
[illegible]	YTD CHARGES -	191.64		YTD PAYMENTS -	175.14		THIS MONTH -		77.50	63.64
[illegible]	[illegible]			[illegible]	05	F	01-18-71	9910	100.00	100.00
						M			9.50	9.00
						F			20.00	20.00
						M			14.00	
						F			15.00	15.00
						M			110.00	110.00
						F			120.00	110.00
						M				
						F				
						M				

Exhibit V-221

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPORT MS25 YTD
DECEMBER, 1970
PAGE 0460

YEAR TO DATE

RECIPIENT PROFILE REPORT

DATES OF SERVICE FROM	TO	----PROVIDER----- NUMBER	TYPE	SPEC	ADJ CODE	CLAIM NUMBER	----PRIMARY DIAGNOSIS---- CODE - DESCRIPTION	-----PRIMARY PROCEDURE-- CODE - DESCRIPTION	PSY CARE	PLACE OF SERVICE	PAYMENT THIS CLAIM
DATE DISPENSED		PROVIDER NUMBER	PRESCRIBER NUMBER		ADJ CODE	BATCH-CLAIM NUMBERS	RX NUMBER	---DRUG CODE AND NAME---------	QTY DPS	DAYS SUP	R C	L T	S D	PAYMENT THIS CLAIM
11-30-70		28010197	0000000000			0745405-0003588372	102187	0486036601-PREMARIN TABS 2.5MG	050	030	0	2		5.75
11-30-70		28010197	0000000000			0341133-0003588373	102185	0038020523-DECLOMYCIN CAPSULES	012	005	0	2	1	4.01
11-30-70	11-30-70	154280937	06	G-P		7035705391	4010-ESSENT BNIGN HYPRTNS	00010-OFFICE VISIT ROUTINE R			OFFI			6.00
								TOTAL THIS YEAR --						517.55

02300000820					BERGEN	ASST DEPEND CHILDREN	PS-31	AGE-17	SEX-F	RACE-1	MAR-1	PREV--		
01-12-70	01-03-70	00010085	04			0009700469		00000-OTHER						30.00
	28010197	0000000000				0034958-0005025041	004896	074834601-ERYTHROCIN FILMTABS	016	004	0	2	0	6.00
01-12-70	01-12-70	154280937	06	G-P		7011E05819	5800-CYSTITIS	00010-OFFICE VISIT ROUTINE R			OFFI			6.00
	28010197	0000000000				0055128-0005025074	001460	A801C00001-A A UNLISTED LEG B	120	001	0	2	0	2.00
	28010197	0000000000		A		0055128-0005025074	001460	0338027164-VAGITROL VAG CREAM	120	001	0	2		2.00
01-19-70	01-19-70	154280937	06	G-P		7005201470	5800-CYSTITIS	00010-OFFICE VISIT ROUTINE R			OFFI			6.00
		28010197	0000000000			0055128-0005014144	0001460	0172036E70-PHISPHOSODA/MOR TABLE	0001	001	0	2		2.00
		28010197	0000000000			0055128-0005014145	0001460	0003-00000-PENICILLIN OINTMENT 0.0	010	001	0	2		2.00
		28010197	0000000000			0055128-0005014101	0001460	0038020523-DECLOMYCIN CAPSULES	012	005	0	2	1	4.01
		28010197	0000000000			0055128-0005014102	0001460	0172036E70-PHISPHOSODA/MOR TABLE	120	001	0	2		2.00
01-						7005000000	4900-BRONCHITIS,UNSPECIFD	00010-OFFICE VISIT ROUTINE R			OFFI			6.00
						0170E05-0005014221	0001460	0056610050-DECAMYCIN TABLETS	050	007	0	2		7.13
02-		154280937	06	G-P		7011E05E80	6460-SACRO-ILIO SPRAIN/STRAIN	00010-OFFICE VISIT ROUTINE R			OFFI			6.00
		0000000000				0170E05-0005014491	0001460	0745E46601-ERYTHROCIN FILMTABS	004	004	0	2	1	7.13
		154280937	06	G-P		7010E04002	4620-PHARYNGITIS,ACUTE	00010-OFFICE VISIT ROUTINE R			OFFI			6.00
		0000000000	01			0031E00000	0016-OTHER	00000-OTHER						330.40
		154280937	06	G-P		7010E04004	5800-NEPHRITIS,ACUTE	99213-LIMIT 1MV ROUTINE R			INPA			
		154280937	06	G-P		7030E03984	5800-NEPHRITIS,ACUTE	00000-HOSPITAL VISIT ROUTE R			INPA			01.00
		0000000000	04			0032000000		00000-OTHER						5.00
10-20-70	10-20-70	154280937	06	G-P		7030E04E46	4650-UP RESP INF,MULT STS	00010-OFFICE VISIT ROUTINE R			OFFI			6.00
								TOTAL THIS YEAR --						* 520.19

02E0100041301					BERGEN	ASST DEPEND CHILDREN	PS-31	AGE-49	SEX-F	RACE-1	MAR-4	PREV--		
	28010197	0000000000				0072E64-0009103625	501483	0456036601-PREMARIN TABLETS 1.2	030	005	1	2	0	
		0000000000				3087018-0000105003	6001464	0004870560-FERRO-SEQUELS	0001	000	0	2	0	
		0000000000				0009022-0000186016	7814965	0456036601-PREMARIN TABLETS 1.2	0030	000	0	2		
		0000000000				0[illegible]-[illegible]	7[illegible]	0456036601-PREMARIN TABLETS 1.2	0030	000	0	2		
		0000000000				0224028-0002607005	7802173	0456036601-PREMARIN TABLETS 1.2	0030	000	0	2		
		0000000000				0[illegible]-0000[illegible]	[illegible]	0514250068-DOXINATAL TABLETS	100	000	0	2		
02-		154280937	06	G-P		7003703448	5820-DUODENUM,ULCER	00010-OFFICE VISIT ROUTINE R			OFFI			6.00
01-05-		0000000000	04			7011[illegible]		-OTHER						
		28010197				[illegible]	0[illegible]	0[illegible]-[illegible]-A CHOTS	010	001	0	2		
		28010197				[illegible]	[illegible]	0514250068-DOXINATAL TABLETS	100	000	0	2		
		28010197				0[illegible]-0000[illegible]	817417	0456036601-PREMARIN TABLETS 1.2	0030	000	0	2		
		28010197				0[illegible]-0000[illegible]	817414	0000000010-LASIX TABLETS 40MG	014	014	0	2		
								TOTAL THIS YEAR --						

0[illegible]	[illegible]	[illegible]	04		VIRGINI	BERGEN	ASST DEPEND CHILDREN	PS-31	AGE-12	SEX-F	RACE-1	MAR-1	PRE--	

Exhibit W-222

DIVISION OF LABORATORIES AND RESEARCH

PAGE 42

PATIENT PROFILE

DESCRIPTION OF CODES

Exhibits V-23 to V-31 provide a description of the codes used in the surveillance exception and detail reports.

Adjustment code

blank - no adjustment
A - adjustment

Discharge status code

1 - still patient
2 - discharged
3 - deceased
4 - transferred

Drug refill code

0 - original
1 - 1st refill
2 - 2nd refill

Group code

0 - no group
1 - medical group
2 - hospital based

Marital status code

1 - single
2 - married
3 - separated
4 - divorced
5 - widow/widower

Psychiatric care code

R - regular care
P - psychiatric care

Race code

1 - white
2 - negro
3 - american indian
4 - latin american
5 - oriental
6 - other

Sex code

M - male
F - female

Special drug code

0	No Significance
1	Anti-Infectives (Including Anti-Biotics)
2	Anti-Obesics and Anorexics
3	Oral Contraceptives
4	Insulin
5	Vitamins
6	Unassigned
7	Paragoric
8	Injectables (Other than Insulin)
9	Unassigned

Exhibit V-24

CATEGORY CODES

10	Old Age Assistance
20	Disability Assistance
30	Assistance for Dependent Children
50	Blind Assistance
60	Bureau of Children's Services
70	Medical Assistance for Aged - State Program
80	Cuban Refugee
90	Other

COUNTY CODES

01	Atlantic
02	Bergen
03	Burlington
04	Camden
05	Cape May
06	Cumberland
07	Essex
08	Gloucester
09	Hudson
10	Hunterdon
11	Mercer
12	Middlesex
13	Monmouth
14	Morris
15	Ocean
16	Passaic
17	Salem
18	Somerset
19	Sussex
20	Union
21	Warren
35	Delaware
63	New York
69	Pennsylvania
Other	Other State

HOME HEALTH AGENCIES SERVICE CODES

02	Skilled Nursing Care
03	Home Health Aide
10	Physical Therapy
11	Speech Therapy
12	Occupational Therapy
23	Supplies-Medical/Surgical
25	Equipment
26	Other
27	Other
28	Other
32	Other

PLACE OF SERVICE CODES

0	EMER
1	OFFI
2	HOME
3	INPA
4	ECF
*5	SKNH
6	LAB
7	OUTP
8	CLIN
9	OTHR

*Use for pharmacy long term care code

PROGRAM STATUS CODES/MINOR CATEGORY CODES

OLD AGE ASSISTANCE

11 OAA - Money Payment Recipient
12 OAA - No Money Payment
13 OAA - Categorically Related, No Money Payment

DISABILITY ASSISTANCE

21 DA - Money Payment Recipient
22 DA - No Money Payment
23 DA - Categorically Related, No Money Payment

ASSISTANCE FOR DEPENDENT CHILDREN

31 ADC - Regular, Money Payment Recipient
32 ADC - Regular, No Money Payment
33 ADC - Regular, Categorically Related, No Money Payment

37 ADC - Unemployed Father, Money Payment, Federally Matchable
38 ADC - UF, No Money Payment, Federally Matchable
39 ADC - UF, Categorically Related, No Money Payment, Federally Matchable

44 ADC - Insufficient Income, Non-Federally Matchable

ASSISTANCE FOR THE BLIND

51 AB - Money Payment Recipient
52 AB - No Money Payment
53 AB - Categorically Related, No Money Payment

BUREAU OF CHILDREN'S SERVICES

60 (To be furnished at a later date)
71 Medical Assistance to Aged (State)
80 Cuban Refugee

90 Other
98 None of the above
99 Ineligible

PROVIDER TYPE (BENEFIT) CODES

01	Inpatient Hospital
02	Mental Hospital
03	T.B. Hospital
04	Outpatient Hospital
05	Outpatient Clinic
06	Physician
07	Podiatrist
08	Optometrist
09	Dentist
10	Pharmacy (Drugs)
11	Home Health Agency
12	Nursing Home
13	Optical Appliance
14	Lab
15	Ambulance
16	Medical Supply
17	Prosthetic Device

SERVICE DEPARTMENT/CLINIC CODES

1	CLINIC (CLIN)
2	SKILLED NURSING CARE (NURS)
3	HOME HEALTH AIDE (AIDE)
4	(OPEN)
5	ROOM CHARGES
6	NURSERY
7	OPERATING ROOM
8	DELIVERY ROOM
9	EMERGENCY/OPERATING ROOM (EMER)
10	PHYSICAL THERAPY (PT)
11	SPEECH THERAPY (ST
12	OCCUPATIONAL THERAPY (OT)
13	RADIATION THERAPY (RADT)
14	INHALATION THERAPY/OXYGEN THERAPY (OXYT)
15	LABORATORY (LAB)
16	X-RAYS (X-RAY)
17	EKG's (EKG)
18	EEG's (EEG)
19	ADMINISTRATION OF ANESTHESIA
20	ADMINISTRATION OF BLOOD
21	BLOOD
22	PHARMACY (PHAR)
23	SUPPLIES-MEDICAL/SURGICAL (SUPP)
24	AMBULANCE-HOSPITAL (AMBU)
25	EQUIPMENT
26	OTHER
27	OTHER
28	OTHER
29	MEDICARE DEDUCTIBLE
30	MEDICARE CO-INSURANCE
31	MEDICARE OTHER
32	OTHER
33	(OPEN)

SPECIALTY CODES

Code	Abbreviation	Specialization/Description
01	G-P	General Practice
02	G-S	General Surgery
03	ALLER	Allergy
04	ENT	Otology, Laryngology, Rhinology
05	ANES	Anesthesiology
06	CV	Cardiovascular Disease
07	DERMA	Dermatology
08	FAM P	Family Practice
09	GYN/DO	Gynecology (Osteopaths only)
10	GASTR	Gastroenterology
11	INTER	Internal Medicine
12	MAN/DO	Manipulative Therapy (Osteopaths only)
13	NEURO	Neurology
14	NEURO	Neurological Surgery
15	OB/DO	Obstetrics (Osteopaths only)
16	OB/GYN	OB - Gynecology
17	ENT/DO	Ophthalmology, Otology, Laryngology, Rhinology (Osteopaths only)
18	OPHTH	Ophthalmology
19	DDS	Oral Surgery (DDS)
20	ORT SU	Orthopedic Surgery

Code	Abbreviation	Specialization/Description
21	PAT/DO	Pathologic Anatomy; Clinical Pathology (Osteopaths only)
22	PATH	Pathology
23	PV/DO	Peripheral Vascular Diseases or Surgery (Osteopaths only)
24	PLAST	Plastic Surgery
25	REHAB	Physical Medicine and Rehabilitation
26	PSYCH	Psychiatry
27	PSY/DO	Psychiatry, Neurology (Osteopaths only)
28	PROCT	Proctology
29	PULMO	Pulmonary Diseases
30	RADIO	Radiology
31	XRY/DO	Roentgenology, Radiology (Osteopaths only)
32	RAD/DO	Radiation Therapy (Osteopaths only)
33	THORS	Thoracic Surgery
34	UROLO	Urology
35	PEDIA	Pediatric
36	OPTOM	Optometrist
37	DMD	Dentist (DMD)
48	PODIA	Podiatry - Surgical Chiropody
49	MISCE	Micellaneous
50	PHARM	Pharmacy
51	SUPP/O	Medical Supply Facility (certified in Orthotics)

Code	Abbreviation	Specialization/Description
52	SUPP/P	Medical Supply Facility (certified in Prosthetics)
53	SUP/OP	Medical Supply Facility (certified in Orthotics and Prosthetics)
54	SUPP	Medical Supply Facility not included 51, 52, 53
55	OPTIC	Optician
59	AMBUL	Ambulance Service
69	LAB	Independent Laboratory
70	CLINI	Clinic
88	HOSPI	Hospitals and Home Health Agencies
99	UNKN	Unknown

APPENDIX B

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

BUREAU OF MEDICAL CARE SURVEILLANCE

RECOVERY PROCEDURES

DEPARTMENT OF INSTITUTIONS AND AGENCIES

INTER - OFFICE COMMUNICATION

TO Recovery Unit Staff Date December 19, 1974

FROM Murray Goldberg, Supervising Medical Review Analyst
Bureau of Medical Care Surveillance

SUBJECT Referral of Cases to A. G.

As of this date the procedures set forth in my memo of November 16, 1973 are supplanted by the following procedure:

All new cases that are to be referred to the A. G.'s office are to be forwarded through Mr. Damiano and only after he has signed the transmittal memo.

MG:db

Boniface J. Damiano
Chief

November 16, 1973

Murray Goldberg
Supervising Medical Review Analyst

Re: Communication to Robert E. Popkin,
Deputy Attorney General

This will confirm our conversation of this date in which it was agreed that:

1. In established cases, the Medical Review Analysts can communicate with Mr. Popkin by memo or phone as necessary. Memos to go over, their own signature.

2. On new cases to be presented to Mr. Popkin, if the case is of a type that has been handled previously raising no new problems or questions, the Medical Review Analyst will write the memo to Mr. Popkin over the signature of the Supervising Medical Review Analyst.

3. On new cases that raise a new problem regarding policy or procedure, the memo to Mr. Popkin will be written by the Supervising Medical Review Analyst for Mr. Damiano's signature.

md

BUREAU OF MEDICAL CARE SURVEILLANCE

Recovery Rules

A. With respect to Medicaid claims, the following rules apply:

1. If the Medicaid payments were incorrectly or illegally made, then recovery can be effected at any time either from the recipient or his estate:

(i) pursuant to the judgment of a court of competent jurisdiction, or

(ii) by voluntary repayment by the recipient.

2. If the Medicaid payments were correctly made, then the following rules apply:

a. No recovery can be effected during the lifetime of the recipient either in or out of court, except by voluntary repayment.

b. Recovery can be effected after the recipient's death only if the following conditions exist:

(i) The recipient leaves no surviving spouse; and

(ii) The recipient leaves no surviving children under 21 years of age or who are blind or permanently and totally disabled; and

(iii) The amount recovered involves Medicaid payments made after the recipient reached the age of 65.

B. With respect to M.A.A. claims, the following rules apply:

1. In an incorrect payment situation, the same rules which apply to Medicaid claims apply to M.A.A. claims.

2. In correct payment situations, the Medicaid rules apply, except that recovery can be effected after the death of the surviving spouse irrespective of whether or not there are any surviving children under 21 or who are blind or permanently and totally disabled.

BUREAU OF MEDICAL CARE SURVEILLANCE

COMPROMISE PROCEDURES

In the Fall of 1974, a meeting was held with the former Division Director, Deputy Attorney General Popkin, and members of the Bureau of Medical Care Surveillance and Bureau of Claims and Accounts. The purpose of the meeting was to develop guidelines and procedures for compromising settlements of cases emanating from each of the two aforementioned Bureaus.

The former Division Director directed that compromise authority would rest with the following combination of individuals. The major principle being that it would require two signatures for compromise approval purposes.

Bureau of Medical Care Surveillance

1. In cases that have been referred to Deputy Attorney General Popkin, a compromise may be effected with the signatures and approval by both the Bureau Chief and the Deputy Attorney General.

2. In cases that have been handled solely by Bureau personnel, compromise authority may be effected with the signature and approval of the Bureau Chief and the Division Director.

Bureau of Claims and Accounts

In all cases, compromise of any case handled by the Bureau of Claims and Accounts would require the signature of the Division Director and Deputy Attorney General Popkin.

February 7, 1972

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

BUREAU OF MEDICAL CARE SURVEILLANCE

GENERAL PROCEDURES - NO. 4

SUBJECT: SETTLEMENTS

Whenever Bureau Staff determine that recipients have obtained monies through other insurance, third party liability, and/or other sources, the following actions shall be taken:

1. Prepare a letter notifying the appropriate welfare board that the recipient has received such monies or that such monies are imminently forthcoming.

2. Include in this letter all pertinent information regarding the amount and circumstances under which the monies were obtained.

3. All drafts of such letters will be approved by the Bureau Chief or the Supervising Medical Review Analyst.

Boniface J. Damiano

Boniface J. Damiano
Chief
Bureau of Medical Care Surveillance

BJD:pm

THIRD PARTY LIABILITY

1. Information relating to claims involving potential third party liability is obtained by the Bureau staff through any of the following sources:

   a. The Contractors, on a monthly basis, will submit to the Bureau all claims involving possible third party liability situations.

   b. Notifications from hospitals, physicians, and other providers indicating that a recipient, an attorney, and/or an insurance carrier has requested a copy of a medical bill or medical records concerning a liability situation involving a Medicaid recipient.

   c. Direct correspondence from a recipient, his attorney, or an insurance company requesting information regarding Medicaid expenditures which may be related to an accident.

   d. Third party liability situations obtained through staff review of microfilm screening of recipient profiles and provider paid claims.

2. The Bureau will review all claims and microfilm data by diagnosis and causes of injury or illness which may involve third party liability coverage, i.e., automobile and work related accidents, fractures, falls, or other traumatic injuries.

3. All cases selected for investigation will be recorded in the Bureau's Case Register.

THIRD PARTY LIABILITY (contd)

4. Upon determining the existence of a third party liability situation, the Bureau staff will serve immediate notice to appropriate parties of the Medicaid Program's right of subrogation and its responsibilities under federal and state requirements to seek reimbursement for medical assistance provided to the extent of such legal liability. The legal basis for reimbursement is stated in N.J.S.A. 30:4D-7j.

5. The Bureau staff will review paid claims and microfilm data to determine all treatment and services received by the recipient relating to the liability situation and to determine the total amount of expenditures for which reimbursement is to be sought.

6. After compiling total expenditures relating to the liability situation, the Bureau staff will initiate a claim with the legally responsible third party or his representative, i.e., the insurance company, the Unsatisfied Claim and Judgment Fund, the Workmen's Compensation Court, etc.

7. In situations where the recipient has obtained an attorney to represent him in liability litigation, the Bureau staff will issue a claim to such attorney notifying him of the legal requirement to reimburse the Medicaid Program from the proceeds of the final settlement.

8. In litigation requiring court appearances, the Attorney General's office is duly notified to provide legal representation on behalf of the Division. The Bureau staff will provide whatever assistance

necessary including representing the Bureau in court proceedings.

9. Upon settlement, the responsible party is directed to have drafts made payable to the Treasurer, State of New Jersey.

PREPARED BY PRUDENTIAL

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume 1-61

May 29, 1973

ATTENTION: ALL PROVIDERS (EXCEPT HOSPITALS)

SUBJECT: DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CLAIMS COLLECTIBLE UNDER THE NEW JERSEY "NO FAULT" LAW ARE NOT REIMBURSABLE UNDER THE MEDICAID PROGRAM

INTRODUCTION

Effective April, 1973, the provisions of Chapter I of the Medicaid Provider Manuals denying payment for that part of any benefits covered or payable under any insurance policy have been amended to include any benefits payable under an insurance policy covered by the New Jersey Automobile Reparation Reform Act, P.L. 1972, c.70. This will apply to all claims arising out of accidents occurring on or after January 1, 1973 which are covered by "No-Fault" insurance policies. The following is a brief explanation of some of the provisions of the "No-Fault" law as well as Medicaid's policy regarding claims submitted in "No-Fault" cases.

PROVISIONS OF THE "NO-FAULT" LAW

The New Jersey Automobile Reparation Reform Act, which is commonly referred to as the "No-Fault" Law, became effective January 1, 1973. The "No-Fault" Law requires that every liability insurance policy insuring an "automobile" as defined by the Act against loss resulting from liability imposed by law for bodily injury, death, and property damage arising out of ownership, operation, maintenance, or use of an automobile shall provide "Personal Injury Protection" (PIP) coverage, as set forth in the Act. The PIP benefits include the payment of all reasonable expenses for medical treatment, surgical treatment, dental treatment, professional nursing services, hospital services, rehabilitation services, X-ray and other diagnostic services, prosthetic devices, ambulance services, medication and other reasonable and necessary expenses resulting from the treatment prescribed by certain practitioners licensed by the State of New Jersey.

PIP benefits will be paid without regard to negligence, liability, or fault of any kind to the following classes of recipients:

1. the name insured under the "No-Fault" insurance policy;
2. the members of the insured's family residing in his household who sustained bodily injury as the result of a covered accident;
3. other persons sustaining bodily injury while occupying the automobile of the named insured;
4. other persons sustaining bodily injury while using the named insured's automobile with the permission of the named insured;
5. pedestrians sustaining bodily injury caused by the named insured's automobile or struck by an object propelled by or from such automobile.

Under Federal regulations, the Medicaid Program is mandated to treat third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. In this regard it should be noted that a provision in the "No-Fault" Law states that a claim for a covered loss must be paid within 30 days after it is furnished to the "No-Fault" insurance carrier.

MEDICAID POLICY

Effective June 1, 1973 all claims for medical expenses covered or payable under an applicable "No-Fault" insurance policy will not be reimbursable by the Medicaid Program. This will apply to all claims submitted for payment to the appropriate Contractors on or after June 1, 1973, as well as all claims previously submitted but not yet paid as of that date, which arose out of covered accidents which occurred on or after January 1, 1973.

All providers affected by this policy are directed to determine whether the injuries involved were caused by an automobile accident for which there is "No-Fault" insurance coverage. If it is determined that "No-Fault" insurance coverage exists, providers are hereby directed to seek reimbursement from the recipient's "No-Fault" insurance carrier or from the recipient himself (if payment has been made to him), and not from the Medicaid Program.

Providers must indicate on their claim forms whether or not the injuries involved arose out of an automobile accident. On those claim forms for which there is no specific question regarding whether or not the injuries arose out of an automobile accident, e.g., Hospital Claims, this information must be provided in the "Remarks" box. The statement "Auto Accident - Yes" or "Auto Accident - No" will suffice. Providers must also indicate in the appropriate box on the claim forms marked "Other Insurance or Liability Coverage" whether or not there is "No-Fault" coverage in the particular case. Claim forms which fail to supply this information will be carefully reviewed by the Contractors and may be delayed or returned to the providers for additional information.

All claim forms which indicate that the injuries involved arose out of an automobile accident must contain certain additional information regarding the "No-Fault" status. Providers who receive "No-Fault" payments for care, services or supplies which are less than the provider would have obtained under the Medicaid Program may submit claims for the difference between the "No-Fault" payment and the Medicaid payment to the Contractor with an explanation from the "No-Fault" carrier of the amount of money obtained from the proceeds of the "No-Fault" insurance policy. Providers furnishing services or supplies to recipients injured in accidents which are not covered by an applicable "No-Fault" insurance policy, or for which payment has been denied by the "No-Fault" carrier may submit their claims to the Medicaid Contractor under existing procedures with an attached letter from the carrier denying payment.

All providers who already have been reimbursed by the Medicaid Program for claims arising out of covered automobile accidents occuring on or after January 1, 1973, should reimburse the Medicaid Program as soon as possible after "No-Fault" payments have been received.

Reimbursement to the Medicaid Program resulting from "No-Fault" payments is to be made payable to the "Treasurer, State of New Jersey" and mailed to:

State of New Jersey
Division of Medical Assistance and Health Services
Bureau of Medical Care Surveillance
Post Office Box 2486
Trenton, New Jersey 08625

PREPARED BY PRUDENTIAL

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume 1-62 June 1, 1973

ATTENTION: ALL HOSPITALS

SUBJECT: DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CLAIMS COLLECTIBLE UNDER THE NEW JERSEY "NO FAULT" LAW ARE NOT REIMBURSABLE UNDER THE MEDICAID PROGRAM

INTRODUCTION

Effective April, 1973, the provisions of Chapter I of the Medicaid Provider Manuals denying payment for that part of any benefits covered or payable under any insurance policy have been amended to include any benefits payable under an insurance policy covered by the New Jersey Automobile Reparation Reform Act, P.L. 1972, c.70. This will apply to all claims arising out of accidents occurring on or after January 1, 1973 which are covered by "No-Fault" insurance policies. The following is a brief explanation of some of the provisions of the "No-Fault" law as well as Medicaid's policy regarding claims submitted in "No-Fault" cases.

PROVISIONS OF THE "NO-FAULT" LAW

The New Jersey Automobile Reparation Reform Act, which is commonly referred to as the "No-Fault" Law, became effective January 1, 1973. The "No-Fault" Law requires that every liability insurance policy insuring an "automobile" as defined by the Act against loss resulting from liability imposed by law for bodily injury, death, and property damage arising out of ownership, operation, maintenance, or use of an automobile shall provide "Personal Injury Protection" (PIP) coverage, as set forth in the Act. The PIP benefits include the payment of all reasonable expenses for medical treatment, surgical treatment, dental treatment, professional nursing services, hospital services, rehabilitation services, X-ray and other diagnostic services, prosthetic devices, ambulance services, medication and other reasonable and necessary expenses resulting from the treatment prescribed by certain practitioners licensed by the State of New Jersey.

PIP benefits will be paid without regard to negligence, liability, or fault of any kind of the following classes of recipients:

1. the name insured under the "No-Fault" insurance policy;
2. the members of the insured's family residing in his household who sustained bodily injury as the result of a covered accident;
3. other persons sustaining bodily injury while occupying the automobile of the named insured;
4. other persons sustaining bodily injury while using the named insured's automobile with the permission of the named insured;
5. pedestrians sustaining bodily injury caused by the named insured's automobile or struck by an object propelled by or from such automobile.

Under Federal regulations, the Medicaid Program is mandated to treat third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. In this regard it should be noted that a provision in the "No-Fault" Law states that a claim for a covered loss must be paid within 30 days after it is furnished to the "No-Fault" insurance carrier.

MEDICAID POLICY

Effective June 1, 1973 all claims for medical expenses covered or payable under an applicable "No-Fault" insurance policy will not be reimbursable by the Medicaid Program. This will apply to all claims submitted for payment to the appropriate Contractors on or after June 1, 1973, as well as all claims previously submitted but not yet paid as of that date, which arose out of covered accidents which occurred on or after January 1, 1973.

All providers affected by this policy are directed to determine whether the injuries involved were caused by an automobile accident for which there is "No-Fault" insurance coverage. If it is determined that "No-Fault" insurance coverage exists, providers are hereby directed to seek reimbursement from the recipient's "No-Fault" insurance carrier or from the recipient himself (if payment has been made to him), and not from the Medicaid Program.

Providers must indicate on their claim forms whether or not the injuries involved arose out of an automobile accident. On those claim forms for which there is no specific question regarding whether or not the injuries arose out of an automobile accident, e.g., Hospital Claims, this information must be provided in the "Remarks" box. The statement "Auto Accident - Yes" or "Auto Accident - No" will suffice. Providers must also indicate in the appropriate box on the claim forms marked "Other Insurance or Liability Coverage" whether or not there is "No-Fault" coverage in the particular case. Claim forms which fail to supply this information will be carefully reviewed by the Contractors and may be delayed or returned to the providers for additional information.

All claim forms which indicate that the injuries involved arose out of an automobile accident must contain certain additional information regarding the "No-Fault" status. Providers who receive "No-Fault" payments for care, services or supplies which are less than the provider would have obtained under the Medicare Program may submit claims for the difference between the "No-Fault" payment and the Medicaid payment to the Contractor with an explanation from the "No-Fault" carrier of the amount of money obtained from the proceeds of the "No-Fault" insurance policy. Providers furnishing services or supplies to recipients injured in accidents which are not covered by an applicable "No-Fault" carrier may submit their claims to the Medicaid Contractor under existing procedures with an attached letter from the carrier denying payment.

All providers who already have been reimbursed by the Medicaid Program for claims arising out of covered automobile accidents occuring on or after January 1, 1973, should reimburse the Medicaid Program as soon as possible after "No-Fault" payments have been received.

Reimbursement to the Medicaid Program resulting from "No-Fault" payments is to be made payable to "Prudential" and mailed to:

Provider Services Division
Attention: J. Gamble, Manager
P. O. Box 5000
Millville, New Jersey 08332

SAMPLE

State of New Jersey

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
324 EAST STATE STREET
TRENTON, NEW JERSEY 08625
TELEPHONE
AREA CODE 609
292-7155

ADDRESS REPLY TO:
POST OFFICE BOX 2486
TRENTON, NEW JERSEY 08625

These form letters are sent to the recipients attorney, as appropriate. These establish our claim and the amount.

August 3, 1973

Name
Address
City, State, Zip

Re: Subject
MAST #

Dear _____:

This Bureau has been informed that you are representing _____ in reference to an accident and/or negligence wherein another party may be deemed liable.

The above named is a recipient under New Jersey's Medical Assistance and Health Services Program (Medicaid) N.J.S.A. 30:4D et seq. At a later date this Division shall submit to you, as disbursing attorney, the amount of Medicaid payments to be reimbursed.

Please advise us of the name of the person from whom damages are sought, his/her attorney and insurance company and related policy, claim and file numbers.

We look forward to your prompt reply.

Very truly yours,

Analyst's Name
Medical Review Analyst
Bureau of Medical Care Surveillance

A-1A

S A M P L E

State of New Jersey

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
324 EAST STATE STREET
TRENTON, NEW JERSEY 08608
TELEPHONE
AREA CODE 609
292-7155

ADDRESS REPLY TO:
POST OFFICE BOX 2456
TRENTON, NEW JERSEY 08625

June 29, 1973

Name
Address
City, State, Zip

Re: Subject
HSP #
MAST #

Dear _____:

Please refer to this Division's earlier communication regarding the above-named individual.

A review of our billing records shows that Medicaid is entitled to reimbursement in the amount of _____.

Upon settlement of this case, the check should be made payable to the "Treasurer, State of New Jersey" and directed to my attention at the above address. A copy of the closing statement should accompany your draft.

Very truly yours,

Analyst's Name
Medical Review Analyst
Bureau of Medical Care Surveillance

A-1B

S A M P L E

State of New Jersey

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
324 EAST STATE STREET
NTON, NEW JERSEY 08625
TELEPHONE
AREA CODE 609
292-7155

ADDRESS REPLY TO:
POST OFFICE BOX 2486
TRENTON, NEW JERSEY 08625

August 6,1973

Name
Address
City, State, Zip

Re: Subject
MAST #

Dear _____:

This Bureau has been informed that you are representing _____ in reference to an accident and/or negligence wherein another party may be deemed liable.

The above-named is a recipient under New Jersey's Medical Assistance and Health Services Program (Medicaid) N.J.S.A. 30:4D et seq.

A review of this Division's payment record shows that Medicaid is entitled to reimbursement in the amount of $_____. The reimbursement should be made payable to "Treasurer, State of New Jersey" and directed to my attention at the above address. A copy of the closing statement should accompany your draft.

Please advise us by return mail of the name of the person from whom damages are sought, his/her attorney and insurance company and related policy, claim and file numbers.

We look forward to your prompt reply.

Very truly yours,

Analyst's Name
Medical Review Analyst
Bureau of Medical Care Surveillance

OUT OF STATE CLAIMS

1. The Bureau will receive monthly from the contractors copies of all Claims paid wherein the services were rendered to recipients out of state. Also included, will be a list of total monthly payments for those out of state claims as well as the total number of recipients receiving services in each state.

2. The Bureau staff reviews these out of state claims to determine those recipients who have received medical services in distant states and/or have received medical services out of state on a continuing basis for an extended period of time. Those states bordering New Jersey such as New York, Pennsylvania, and Delaware where it is recognized as the usual customary practice for recipients to obtain services will not be considered for investigation.

3. The Bureau staff will select those claims where the services were rendered in distant states for extended periods of time and initiate an investigation to determine if the recipient is a bona fide resident of New Jersey, and if the appropriate county welfare board is aware of the recipient's out of state status.

4. For each out of state claim selected for investigation, a notification will be sent to the recipient's county welfare board. This notification will advise the recipient's county welfare board of the period of time that the recipient was out of state, the state involved and will also include a copy of the claim. This notification will also request the county welfare board to review the recipient's current status to determine whether the recipient continues to meet residency requirements for welfare and/or Medicaid benefits.

5. The attached notification form will be used by bureau staff in communicating this information to the various county welfare boards.

State of New Jersey

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
324 EAST STATE STREET
TRENTON, NEW JERSEY 08608
TELEPHONE
AREA CODE 609

ADDRESS REPLY TO:
POST OFFICE BOX 2486
TRENTON, NEW JERSEY 08608

Re:

Dear

Please be advised that the New Jersey Health Services Program paid the attached copy of an out-of-state claim for the above name recipient(s).

We share this information with you for the following purposes:

1) to inform you that the recipient was out-of-state on the date this service was received;

2) to request that a determination be made as to whether the recipient continues to meet residency requirements for categorical assistance and/or Health Services benefits.

In order for this office to continue processing of this case, would you kindly complete the attached questionnaire and return the form to the attention of the Bureau of Medical Care Surveillance at the above address.

Very truly yours,

William J. Jones, Director
Division of Medical Assistance
and Health Services

bm

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TO: CASEWORKER FOR

RECIPIENT:

HSP #

MAST #

A. This is to request that the recipient's actual residence be ascertained.

B. Please complete the following:

1. Did the recipient meet residency eligibility requirements at the time of the claim?

_____ ( ) Yes ( ) No
Date of Claim

2. Does the recipient now meet residency requirements for categorical assistance and/or Health Services benefits? ( ) Yes ( ) No

If not, show the date of termination. _____
Date

3. Was the recipient terminated because he was found to be living out-of-state? ( ) Yes ( ) No

4. Please show current mailing address for the recipient.

_____

_____

_____

C. How was this information obtained, i.e., by field visit, or other? Please explain.

_____

_____

_____
Signature of Person Preparing Form

_____
Title and Date

OTHER HEALTH INSURANCE

1. Sources of information relating to other health insurance coverage is obtained by the Bureau through any of the following sources:

   a. The contractors will submit a list of all claims denied payment due to the existence of other health insurance available to the recipient. This list will denote those claims where the other insurance coverage was not indicated on the recipient's eligibility file, but was developed from information contained on the claim form.

   b. Notifications from hospitals, physicians and other providers that a recipient and/or an insurance company has requested copies of a medical bill paid by the Medicaid Program.

   c. Notifications from hospitals, physicians, and other providers that payments were received from an insurance carrier on previously paid Medicaid bills and indicating their willingness to refund the Medicaid payment.

2. After it has been determined that other health insurance coverage does exist the following procedures are taken concerning:

   a. Recipient

      1. Communicate in writing with the recipient requesting the name and address of his insurance carrier, the policy number, and the name of the insurance agent to be contacted. Also, request the dates that the insurance policy was in effect in order to determine from the recipient's detailed profile the total amount of benefits received during the effective period of the policy.

2. If it has been determined that the recipient has already received payment from the insurance carrier for services paid by the Medicaid Program, the Bureau staff will seek reimbursement directly from the recipient and in appropriate instances, request assistance from the county welfare board in obtaining reimbursement.

3. If reimbursement from the recipient cannot be effected, ie. the insurance money is no longer available. The bureau staff will notify the appropriate county welfare board of the date and the amount of money the recipient received from the insurance carrier, and request that a redetermination of the recipient's eligibility be made.

4. For those recipients whose insurance policies are still in effect, but not indicated on the eligibility file, the bureau staff will communicate all pertinent information concerning the recipeint's insurance coverage and request the county welfare board to issue a new MAP form to reflect this other coverage.

b. Insurance Carrier

1. After obtaining the identity of the recipient's insurance carrier, the bureau staff will communicate in writing with the insurance carrier to alert them of Medicaid's interest in obtaining reimbursement of all medical bills paid by Medicaid which may be covered under the recipients existing insurance policy. Include in this letter copies of all medical bills paid by Medicaid and request their evaluation for potential reimbursement.

2. If the recipient has not made a claim against the insurance

carrier, or if final settlement has not been effected, Bureau staff will instruct the insurance carrier to initiate appropriate action to be taken in order to effect direct reimbursement from the insurance carrier of all eligible expenditures made by the Medicaid Program.

3. All checks involving reimbursement to the Medicaid Program will be made payable to "Treasurer, State of New Jersey".

February 7, 1972

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

BUREAU OF MEDICAL CARE SURVEILLANCE

GENERAL PROCEDURES - NO. 2

SUBJECT: OTHER INSURANCE COVERAGE

Whenever other insurance coverage is detected by Bureau staff the following actions will be taken:

1. Obtain the name, address of the insurer, obtain names of all covered recipients, the effective date of the policy, termination date, if any, and the policy number.

2. Determine whether the other coverage is actually health insurance coverage which pays hospital and medical bills or is some type of health benefits' plan such as an indemnity policy which pays "living costs" benefits directly to the recipient and not to the health providers.

3. If you establish that the recipient in fact has other health insurance coverage or indemnity benefits, review the current eligibility file and determine whether or not other coverage is shown.

4. If other insurance coverage exists and is not shown on the current MAP form, the following actions will be taken:

   1) Prepare a letter notifying the appropriate County Welfare Board to issue an updated MAP form reflecting the other coverage. Include in the letter the name, address, and policy number of the insurer.

   2) Prepare extra copies of the letter for both Contractors and show: cc: Prudential Insurance Company, Blue Cross.

   3) Review microfilm utilization histories to determine Medicaid payments which should have been paid through the other health insurance. Recapture Medicaid payments, if applicable.

Boniface J. Damiano

Boniface J. Damiano
Chief
Bureau of Medical Care Surveillance

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume 1-17 April 2, 1971

TO: Hospital Administrators

SUBJECT: NEW JERSEY HEALTH SERVICES PROGRAM AND OTHER INSURANCE

The policy of the New Jersey Health Services Program concerning "other insurance" is stated in Section 110.3 (page 9) of the Health Services Program Hospital Manual:

> "When a covered person has other health insurance, the Program requires that such benefits be used. Supplementation shall be made by the Program when necessary but the combined total shall not exceed the amount payable under the Program in the absence of other coverage".

We have been advised that on occasions "medical assistance recipients" have requested statements of benefits paid in their behalf by the New Jersey Health Services Program (Medicaid). It is believed that some of these recipients might be covered either in part or in whole by some other type of health insurance. Therefore, if you have a record of having provided a duplicate statement of benefits to a recipient or receive such a request in the future, please notify the Bureau of Medical Care Surveillance, P.O. Box 2486, Trenton, New Jersey, 08625 of the patient's full name, address and Health Services Program case number.

Such information will enable the Bureau to investigate such cases to determine possible fiscal responsibility of another carrier, and ultimately reduce unnecessary payments by the Health Services Program.

OTHER RESOURCES

1. Information relating to recipients' actual or potential resources is obtained by the Bureau staff through any of the following sources:

   a. The Property and Resource section of the various county welfare boards will submit to the Bureau information concerning patient resources which become available through the sale of homes, real estate, and other types of property.

   b. Through the voluntary contributions of the recipient's family, relatives, and attorneys involved in the settlement of the recipient's estate.

   c. From the assigned or unassigned life insurance policies held by the various county welfare boards.

2. Action taken by Bureau staff whenever notification is received concerning the availability of property and other resources owned by a Medicaid recipient.

   a. Obtained a complete accounting from the Bureau of Claims and Accounts of the total expenditures provided to the recipient for nursing home care.

   b. From a review of the recipient's profile reports, obtained the total expenditures made on behalf of the recipient for all services.

OTHER RESOURCES (contd)

c. Communicate in writing to the individual responsible for handling the recipient's estate or property, i.e., the administrator, attorney, executor, etc., advising that:

1. In the event of the demise of a recipient over 65 with no surviving spouse or no child under 21 who is blind or disabled, the Medicaid Program under federal and state law, is required to seek reimbursement from the estate for those benefits received by the recipient after age 65.

2. In the event that a recipient, during his lifetime, who comes into available resources through sale of property, life insurance, etc., the Medicaid Program is required to seek reimbursement from the proceeds of this available resource on a voluntary basis or move to have the recipient's eligibility redetermined in the light of this available resource.

d. All cases investigated shall be recorded in the Bureau's Case Register and any checks received will be made payable to Treasurer, State of New Jersey.

e. The Bureau staff will seek the assistance of the Deputy Attorney General for those cases requiring court adjudication of recipients' estates.

Department of Law and Public Safety — Inter-Communication

From: Robert E. Poplin, Deputy Attorney General

To: Boniface J. Damiano, Chief, Bur. of Medical Care Surveillance (Institution or Department)

Date: January 15, 1974

Re: Claims Against Estates

Members of the Bureau have requested that I summarize relevant provisions of the New Jersey Statutes relating to claims against estates.

What follows is a brief summary of N.J.S.A. 3A:24-1 through N.J.S.A. 3A:24-11:

1. N.J.S.A. 3A:24-1

This provision defines "claim" to include "debt and demand," and "creditor" is defined as meaning "a person having a claim."

2. N.J.S.A. 3A:24-2

This provides that the following expenses and debts shall have preference and shall be paid out of the personal and real estate of the decedent in the following order:

a. Funeral expenses;
b. Administration expenses;
c. Debts entitled to a preference under the laws of the U.S.;
d. Hospital, physicians' and nurses' bills during the last illness;
e. Judgments entered against the deceased according to the priority of their entries respectively.

If a judgment has been entered against a decedent during his lifetime, such as would be the case in an incorrect or illegal payment situation, then of course such a Medicaid judgment could qualify for priority under the last section of this provision. Under our present statute, however, we have no statutory liens and cannot consider our claims to be "judgments" unless a judgment was actually entered during the lifetime of the decedent by a court of competent jurisdiction.

I believe that an argument could be made that Medicaid payments could qualify as hospital or physicians' bills, providing

that they were incurred during the "last illness."

Finally, since no federal statute provides that a Medicaid claim is "entitled to a preference" we cannot qualify under the third category of preferred claims.

3. N.J.S.A. 3A:24-3

This provides that at any time after the granting of letters testamentary or letters of administration "either the Superior Court, County Court, or Surrogate" may order the executor or administrator of the estate to give "public notice " to creditors of the decedent to present to him within six months from the date of the order their claims. The provision requires that the claims be presented "in writing and under oath, specifying the amount claimed and the particulars of the claim." Normally, I satisfy these requirements by filing a "Proof of Claim" which is notarized. I am enclosing a form Proof of Claim for your information.

4. N.J.S.A. 3A:24-4

This provision is not relevant for our purposes, since it deals with liquidated claims "not due and payable, but payable in the future. . . ."

5. N.J.S.A. 3A:24-5

This provision is also not relevant for our purposes.

6. N.J.S.A. 3A:24-6

This provides that within three months after the presentation of a claim to an executor or an administrator, the excutor or administrator "shall allow or dispute it or allow it in part or dispute it in part, and give notice in writing to the creditor, his agent or attorney, of that which he allows or disputes."

In addition, within three months after the creditor receives notice that a claim or a part of the claim has been disputed, the creditor "shall commence an action to recover on the claim or so much of it as is disputed. . . ." If the creditor does not commence an action within the three months period, the executor or administrator "shall not be liable to the creditor with respect to any assets which he may have delivered or paid in satisfaction of any lawful claims, legacies or distributive shares before the commencement of such an action."

It is therefore very important that in cases in which N.J.S.A. 3A:24-3 does not apply, i.e., an order limiting creditors has not been published and therefore the six-month time period does not apply, upon receipt of a notice from an executor or administrator that he disputes all or part of our Medicaid claim, I should be notified as soon as possible after that notice has been received in order that I may commence suit within the three-month time limit.

7. N.J.S.A. 3A:24-7

This provision relates to N.J.S.A. 3A:24-3, and provides that if a claim is not presented to the executor or administrator of an estate under oath and within the six month period of time provided in N.J.S.A. 3A:24-3, then "the executor or administrator shall not be liable to the creditor with respect to any assets which he may have delivered or paid in satisfaction of any lawful claims, legacies or distributive shares before the presentation of such claims."

8. N.J.S.A. 3A:24-8

This provision provides a remedy for creditors who fail to present their claims within the time limits set forth in N.J.S.A. 3A:24-3. When the assets of an estate exceed the amount needed to pay claims which have been presented within the time limts set forth in N.J.S.A. 3A:24-3, a claimant who has failed to present his claim within the time limits may still present his claim in the proper form to the executor or administrator at any time before the remaining assets of the estate have been distributed or paid over pursuant to law.

After receipt of such a claim, this section provides that the executor or administrator "shall, if satisfied that the claim is correct and should be paid, pay the same or so much thereof as the amount of the assets available for distribution will permit." If the administrator is not satisfied with the correctness of the claim, he shall notify the claimant, his agent or attorney, "to proceed forthwith to establish the disputed claim, or part thereof, by judgment." In such a case, the executor or administrator "shall retain from the assets available for distribution a sum sufficient to pay the amount of the claim, together with interest and costs, until such time as the claimant shall have had an opportunity to establish his claim by judgment."

9. N.J.S.A. 3A:24-9

This section provides that if an executor or administrator fails to pay a claim presented pursuant to N.J.S.A. 3A:24-8, the claimant may bring an action against the executor or administrator to recover on his claim in any court of competent jurisdiction.

10. N.J.S.A. 3A:24-10

This section provides that if a creditor fails to commence an action upon his claim within one month after being notified to establish his claim by judgment pursuant to N.J.S.A. 3A:24-8, "he shall be thereafter forever barred from any action against the executor or administrator to recover on the claim."

11. N.J.S.A. 3A:24-11

This section provides that an executor or administrator cannot be compelled to pay any claim which is not presented within the six-month time period set forth in N.J.S.A. 3A:24-3 "unless the court to which he is accountable shall, for good cause shown, so direct or until his account has been settled by the court and the court has authorized or directed him to make the payment."

If any of you have any questions with regard to any of the above provisions, feel free to contact me.

R.E.P.
R.E.P.

REP:med
Att.
cc: Murray Goldberg, Supervising Medical Review Analyst, Bur. of Medical Care Surveillance
William Griffin, Medical Review Analyst, Bur. of Medical Care Surveillance
Frank Damon, Medical Review Analyst, Bur. of Medical Care Surveillance
Henry Josephick, Medical Review Analyst, Bur. of Medical Care Surveillance

SAMPLE

GEORGE F. KUGLER, JR.
Attorney General of New Jersey
State House Annex
Trenton, New Jersey 08625

BY: ROBERT E. POPKIN
Deputy Attorney General
(609) 292-8554

MONMOUTH COUNTY SURROGATE'S OFFI
DOCKET NO. 103795

IN THE MATTER OF THE ESTATE)
OF)
[redacted], DECEASED) Civil Action
) PROOF OF CLAIM
STATE OF NEW JERSEY))
COUNTY OF MERCER) SS.

ROBERT E. POPKIN, of full age being duly sworn according to law upon his oath deposes and says:

1. I am the Deputy Attorney General assigned to represent the Division of Medical Assistance and Health Services, Department of Institutions and Agencies, State of New Jersey, which administers the New Jersey Medical Assistance and Health Services (Medicaid) Program.

2. Between January, 1971 and July 13, 1973, the decedent, [redacted], was a recipient of benefits under the New Jersey Medicaid Program while at the Tower Lodge Nursing Home, Neptune, New Jersey.

3. During the aforementioned period of time, the New Jersey Medicaid Program expended $13,141.15 on behalf of [redacted] for nursing home care.

4. The amounts of nursing home benefits paid on behalf of [redacted] are set forth in a Statement of Medicaid Payments, a copy of which is annexed hereto as Exhibit "A".

5. In addition, $119.48 was also expended on behalf of [redacted] for physicians' services, pharmaceutical items, and other care during the aforementioned period of time.

6. Therefore, during the aforementioned period of time, a total of $13,260.63 was expended on behalf of [redacted] under the New Jersey Medicaid Program.

7. I hereby file a claim for reimbursement on behalf of the Division of Medical Assistance and Health Services, Department of Institutions and Agencies, State of New Jersey in the amount of $13.260.63.

GEORGE F. KUGLER, JR.
Attorney General of New Jersey

By: _____
Robert E. Popkin
Deputy Attorney General

Sworn and subscribed to
before me this 8th day
of January, 1974

Elizabeth M. Thomas

DATE 5-10-73

CLIENT NAME [redacted] 1/25/71

PATIENT # 13100 15178-01 000

NURSING HOME Tower Lodge N.H. 13300

STATEMENT OF MEDICAID PAYMENTS

MONTH OF PAYMENT	NUMBER OF DAYS	GROSS PAYMENT	INCOME	NET PAYMENT	PAYMENT ADJUSTMENTS
11/71	10	167.10		167.10 ✓	
12/71	28	467.88	85.80	382.08 ✓	
1/71	31	518.01	85.80	432.21 ✓	
2/71	30	509.40	85.80	423.60 ✓	
3/71	31	526.38	85.80	440.58 ✓	343.20 ✓
4/71	30	501.30	90.40	410.90 ✓	6.10 ✓ +40.40
5/71	31	526.38		526.38 ✓	
6/71	31	526.38		526.38 ✓	
7/71	30	509.40		509.40 ✓	
8/71	31	526.38	742.40	216.02 ✓	
9/71	30	509.40		509.40 ✓	
10/71	31	526.38		526.38	
11/71	31	539.40	206.20	333.20	
12/71	29	504.60	206.20	298.40	
1/72	31	539.40	206.20	333.20	103.11
2/72	30	522.00	190.90	331.10	
3/72	31	539.40	108.70	430.70	
4/72	30	522.00	95.70	426.30	
5/72	31	553.04	95.70	457.34	
TOTAL	557	9,534.23	2,265.60	7,464.65	544.80
ADJUSTMENT					
GRAND TOTAL					

NC-NH - 33 (1-72)

EXHIBIT "A"

BUREAU OF CLAIMS & ACCOUNTS

DATE 5/16/73

PATIENT NAME [redacted]

PATIENT # 13100 15178-01

NURSING HOME Tower Lodge N.H. 13307

1/25/71

Cont

STATEMENT OF MEDICAID PAYMENTS

MONTH OF PAYMENT	NUMBER OF DAYS	GROSS PAYMENT	INCOME	NET PAYMENT	PAYMENT ADJUSTMENTS
8/72	31	553.04	95.70	457.34	17.98
9/72	30	552.60	95.70	456.90	
10/72	31	571.02	117.50	453.52	
11/72	30	552.60	117.50	435.10	
12/72	31	571.02	117.50	453.52	
1/73	31	585.28	105.50	479.78	
2/73	28	528.64	113.50	415.14	
3/73	31	585.28	113.50	471.78	
4/73	30	566.40	113.50	452.90	
5/73	31	585.28	113.50	471.78	
6/73	30	566.40	113.50	452.90	
7/73	12	226.56	113.50	113.06	
Subtotal	346	6401.12	1330.90	5113.72	17.98
TOTAL	903	15,978.35	3,616.00	12578.37	
+ ADJUSTMENT				562.78	
= GRAND TOTAL				13,141.15	

ROLE OF CONTRACTORS

The Bureau of Medical Care Surveillance, in order to maintain efficiency and avoid duplication, has coordinated and integrated the surveillance systems of the Contractors, namely, the Hospital Service Plan of New Jersey and the Prudential Insurance Company, with those of the Bureau.

The Bureau of Medical Care Surveillance has established direct liaison with the Contractors for purposes of interchanging information and assisting and forwarding the Bureau's operations.

The Contractors will assist the Bureau in the below-listed areas, in accordance with specified procedures.

1. Third Party Liability
2. Other Health Insurance
3. Workmen's Compensation
4. Out-of-State Claims
5. Post Payment Review
6. Overpayments
7. Hospital Utilization Review Committee

Third Party Liability

1. The Contractors will review claims by diagnosis and by analysis of possible cause(s) of illness or injury which potentially involve third party liability insurance, i.e., auto accident, fracture, fall or other traumatic injury. Claims to be reviewed would include those amounting to over fifty dollars ($50).

2. The Contractors will process these claims for payment and will not initiate any investigations.

3. Until further notice, the Contractor will accumulate copies of claims with possible third party liability. These claims will be batched on a monthly basis and forwarded to the Bureau by the fifth working day following the end of the month.

4. The Contractors will also provide a monthly listing of all submitted claims. The list will include patient name, case number, person number, date of service, name of provider, amount billed and amount paid. Summary data will include total number of claims, total amount billed and total amount paid.

Other Health Insurance

1. The Contractors will match all institutional claims against the Eligibility File in order to determine if recipients have other insurance coverage. In addition, the Prudential Insurance Company will match against the Eligibility File all Physicians' and Practitioners' Claims wherein services were rendered in an institution to determine the existence of other insurance coverage. Additional benefit areas will be included as experience indicates.

2. In matching claims against the Eligibility File the Contractors will verify whether

   a. those claims which do not indicate other insurance coverage do in fact have some type of insurance coverage.

   b. those claims which do indicate other insurance coverage are in fact indicated on the Eligibility File.

   The Contractors will make the appropriate corrections in their respective eligibility files.

3. In cases where the Eligibility File indicates other insurance and the prior information file does not reveal the details of the other insurance coverage, the Contractors communicate by letter to the appropriate County Welfare Board to obtain the name of the carrier and policy number.

   In cases where the claim indicating other insurance coverage is not so indicated on the Eligibility File, the Contractors

will write to the appropriate County Welfare Board notifying it of the existence of other insurance and the details if known. The County Welfare Board will then make the appropriate correction in the recipient's file.

4. When the information is obtained relative to the details of the recipient's other insurance coverage, it is so entered on the claim form, payment is declined and the provider is notified in writing of the other insurance carrier and the patient's policy number and is directed to bill that insurance carrier for first payment.

5. The Contractors will make a monthly exchange by letter listing recipients identified through the county welfare boards as having other coverage, showing insurance carrier and policy number, where available.

6. If a reply from the county welfare board indicates there is no other coverage, the eligibility file will be so corrected, and the Contractors will make payment of the claim.

7. If the county welfare boards do not respond to the Contractors' request for details of the recipient's other insurance coverage within 30 days, the claim will be declined and the provider so notified, with a copy sent to the appropriate county welfare board.

Other Health Insurance cont'd.

8. Contractors will submit a listing of declined cases to the Bureau by the fifth working day following the end of the month in which these cases occurred. The list will include patient name, number and person number, admission date, provider name and number, amount billed and amount payable by the Program. Summary data will include total number of claims declined, total amount billed and total amount payable without insurance coverage. This list will denote those cases where the other coverage have not been indicated on the eligibility file, but was developed from information on the claim form.

Workmen's Compensation

1. For claims identified as having other insurance coverage, the Contractors will review these claims by diagnosis (including only those 18 years of age and over) and screen those cases when diagnosis appears on a listing of possible work-related conditions. Claims to be reviewed would include those amounting to over fifty dollars ($50).

2. The Contractors will make copies of all such possible work-related claims and will process the original claim for payment. The Contractors will contact the appropriate County Welfare Board within 10 days by letter to determine the client's employment status. If client is reported as unemployed, the investigation is closed. If client is found to be employed, the Contractors will contact the employer and other appropriate sources.

3. If any response indicates that the injury or condition is work-related, the Contractors will submit copies of all data relative to the claim to the Bureau. Accumulated copies of all work-related claims are received by the Bureau by the fifth working day following the end of the month in which the determinations are made.

Out-of-State Claims

1. The Contractors will furnish copies of vouchers of all out-of-state claims paid. These will be accumulated and forwarded to the Bureau by the fifth working day following the end of the month in which the claims were paid.

2. The Contractor will also include a summary indicating the total number of claims paid and total net payment.

Post Payment Review

1. Upon direction from the Bureau, the Contractors, through their professional relations field staff, will perform certain post payment review of Medicaid providers and practitioners.

2. Cases to be reviewed by the Contractors will be selected by the Bureau based on random samples and analysis of the surveillance reports and microfilm data for situations that appear significant. The Bureau will assign the investigative parameters for the Contractors to follow in each case.

3. The Contractors will submit a written report to the Bureau describing the results of their post payment review assignments by the 10th day following the completion of the review.

Overpayments

The Contractors will review and evaluate all overpayments. If determined to be due to clerical error on the part of the provider or Contractor, the necessary adjustment will be made with proper notification to the provider.

In instances where the overpayment appears to result from irregular and questionable provider billing practices, the Contractor will forward a letter of explanation to the Bureau along with appropriate documentation. After reviewing the material, the Bureau will instruct the Contractors to initiate recovery of the overpayment from the provider and to credit the amount to the Program's account. The Contractors will inform the Bureau when recovery and crediting of monies are concluded.

CONTRACTOR ROLE

CLAIMS AND UTILIZATION REVIEW

I. Utilization Review Committee

Since the hospital is required to meet the requirements of Title XVIII concerning utilization review for all medical assistance patients, (Section 203.5 of the Medicaid Hospital Manual) the Contractor will make on-site periodic surveys of the hospitals to assure that the Utilization Review Committee is reviewing extended duration cases and that the hospital is making patterns of care studies which include Medicaid recipients. The Bureau of Medical Care Surveillance will be informed as to the results of such surveys and efforts made to bring into compliance those hospitals which are not implementing this aspect of the Program.

State of New Jersey

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
324 EAST STATE STREET
TRENTON, NEW JERSEY 08608
TELEPHONE
AREA CODE 609

ADDRESS REPLY TO:
POST OFFICE BOX 2486
TRENTON, NEW JERSEY 08608

Re:

DATE DUE:

Dear

The Medicaid Program is investigating a medical claim in which treatment was received by the above referenced person at/by _____ on _____.

CAREFULLY NOTE:

1. Medicaid requires that you complete ALL of the following questions. If a question does not apply show the letters "N/A" in the answer space.
2. You are required to certify that your statements are true to the best of your knowledge and belief.
3. AS A RECIPIENT OF MEDICAID BENEFITS YOU MUST MAKE KNOWN ANY AND ALL OTHER HEALTH INSURANCE COVERAGE TO THE COUNTY WELFARE BOARD BY VISIT, LETTER OR PHONE CALL. THE RETURN OF THIS FORM DOES NOT FULFILL THIS OBLIGATION.

INQUIRY

1. Give phone number where you can be reached during the day.

   Area Code_____ Number _____

PLEASE TURN PAGE

Case File No._____

STATE OF NEW JERSEY

DEPARTMENT OF INSTITUTIONS AND AGENCIES
Division of Medical Assistance and Health Services
Bureau of Medical Care Surveillance

2. Are you covered by any health insurance other than Medicaid? Include health insurance through employment. Yes___ No___ (Please Check)

If yes, complete the following:

_____
Name of Health Insurance

_____
Address

_____
Policy Number Beginning Date of Coverage

3. Have you filed or do you plan to file a claim with your insurance company for any medical expenses billed to Medicaid? Yes___ No___ (Please Check)

4. Was this treatment for injuries caused by an accident? Yes___ No___ (Please Check)

If yes, complete the following:

a. Date of Accident_____

b. Location of Accident_____

c. Type of Accident (fall, auto, etc.)_____

d. Name of police department that investigated or to which this was reported.

_____

e. Describe what happened._____

_____

_____

_____

LD-15 R
12/73 Medicaid

Case File No._____

STATE OF NEW JERSEY

DEPARTMENT OF INSTITUTIONS AND AGENCIES
Division of Medical Assistance and Health Services
Bureau of Medical Care Surveillance

f. Give name and address of all persons or insurance companies including yours or a family member's that may be responsible for payment of medical bills resulting from this accident (attach additional page, if needed).

_____
Name

_____
Address

_____
Policy Number

_____
Phone Number

g. Do you have an attorney handling this accident? Yes___ No___
(Please Check)

If yes, his:

_____
Name

_____
Address

_____
Phone Number

5. Was any other person injured in this accident covered by Medicaid?

Yes___ No___ If yes, please list them below:

_____
Name Medicaid Number

_____
Name Medicaid Number

6. This form must be returned early enough to reach this office no later than the DATE DUE on Page 1.

I certify that to the best of my knowledge and belief the above information and statements are true.

_____
SIGNATURE

_____
DATE

LD-15 Rev.
12/73 Medicaid

SAMPLE

State of New Jersey

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
LAST STATE STREET
TRENTON, NEW JERSEY 08608

TELEPHONE
AREA CODE 609
292-7155

ADDRESS REPLY TO:
POST OFFICE BOX 2486
TRENTON, NEW JERSEY 08608

December 7, 1972

Name
Address
City, State, Zip

Re: Subject
MAST #

Dear _____:

Please refer to this Division's previous correspondence pertaining to the above-named individual. At this time, you are asked to advise as to the current status of this case and provide an approximate date of settlement, whereupon Medicaid will be reimbursed. A reply is necessary to permit further processing of our files on this matter.

Thank you very much.

Very truly yours,

Analyst's Name
Medical Review Analyst
Bureau of Medical Care Surveillance

A-3

EXAMPLE

APPENDIX C

INVENTORY OF COMP[illegible]R PRINTOUTS

REPORT NAME	PURPOSE OF REPORT	FREQUENCY & SEQUENCE	DATES AVAILABLE	SOURCE	DISTRIBUTION
ALPHABETIC PROVIDER LISTING	Contains addresses of providers	Monthly, alphabetic listing	1971 & 1973	Prudential	Health Statistics & Economics, & Surveillance
ALPHABETICAL RECIPIENT LISTING	Reference	Monthly listing (Microfilm)		Blue Cross	Surveillance
BLUE CROSS CLAIMS		Monthly listing (Microfilm)		Blue Cross	H.S. & E., & Surveillance
BLUE CROSS HOSPITAL PROVIDER LIST	NJ & ODS, Status, Type, per diem-hospital, Medicare Medicaid		5/11/73	Blue Cross	Surveillance
CHARGES & PAYMENTS BY PROCEDURE	Specialist & non-specialist charges & payments by procedure & geographic area		2/27/71	Prudential	H.S. & E.
CHARGES & PAYMENTS BY PROCEDURE - MEDICAID	Specialist & non-specialist charges & payments by procedure & geographic area		2/27/71	Prudential	H.S. & E.
CLAIMS PAID WHERE 3RD PARTY LIABILITY IS SUSPECTED		Monthly listing		Blue Cross & Prudential	Surveillance

INVENTORY OF COMPUTER PRINTOUTS

REPORT NAME	PURPOSE OF REPORT	FREQUENCY & SEQUENCE	DATES AVAILABLE	SOURCE	DISTRIBUTION
CLAIMS PROCESSING REVIEW REPORT	Number of claims processed by each provider for each benefit type by age of claim		1970 - Present	Internal	H.S. & E., Surveillance & Dr. Wallerstein
DECLINES OTHER INSURANCE COVERAGE		Monthly listing		Prudential	Surveillance
DENTIST PROVIDER	Contains addresses of providers	Alphabetical & Numerical listing		Prudential	Surveillance
DIAGNOSTIC TABLE	Codes				Surveillance
ELIGIBLE BY AGE, RACE, & SEX WITHIN EACH PROGRAM	March '73 all eligible & non-white eligibles not serviced in 1971, 1972		January '71, '72, '73.	Internal	H.S. & E.
FEDERAL 2082 REPORT	Demographic analysis of all services provided during the fiscal year with unduplicated recipient counts & financial breakdowns by type of service within each county	County listing	FY 1973	Internal	H.S. & E.

INVENTORY OF COMPUTER PRINTOUTS

REPORT NAME	PURPOSE OF REPORT	FREQUENCY & SEQUENCE	DATES AVAILABLE	SOURCE	DISTRIBUTION
FAMILY PLANNING SERVICE	Family planning payments shown by type of service & by eligibility category with total recipients	Monthly by county	1970-Present	Internal	H.S. & E.
FEE SCHEDULE PER PROCEDURE CODE				Prudential	Surveillance
INPATIENT CLAIMS OB-GYN	Listing of Medicaid recipients who received OB-GYN care in 1970 & 1971		1970 - 1971	Internal	H.S. & E.
INPATIENT HOSPITAL SURVEILLANCE REPORT	To report inpatient hospitals whose Medicaid activity exceeds present criteria.	Monthly listing		Internal	H.S. & E., Surveillance one copy is broken up and sent to various departments
INPATIENT HOSPITAL DIAGNOSIS SURVEILLANCE REPORT	Discharged or deceased recipients. Listing of various diagnosis flagged for total charges	Monthly listing	1970 - Present	Internal	H.S. & E., & Surveillance

INVENTORY OF COMPUTER PRINTOUTS

REPORT NAME	PURPOSE OF REPORT	FREQUENCY & SEQUENCE	DATES AVAILABLE	SOURCE	DISTRIBUTION
LISTING OF 9999 HIGHEST PAID PROVIDERS BY SPECIALTY CODE	States dollars paid in current month, year-to-date & total for previous year. Providers are listed on current month payment-high to low with specialty code	Monthly listing by Provider specialty code & Type of service	1970 - Present	Internal	H.S. & E. & Surveillance
LISTING OF MAA CLAIMS				Internal	H.S. & E. & Bureau of Claims & Accounts
LISTING OF PROVIDERS BY SPECIALTY CODE	Listing of providers by specialty code with address	County listing	11/22/70	Internal	H.S. & E.
MEDICAID DIAGNOSIS FILE	Listing of diagnoses and AID allocated to each.		1/31/70	Internal	H.S. & E.
MEDICAID DRUG LISTING			Oct., July, April, Jan. 1970	Internal	H.S. & E.

INVENTORY OF COMPUTER PRINTOUTS

REPORT NAME	PURPOSE OF REPORT	FREQUENCY & SEQUENCE	DATES AVAILABLE	SOURCE	DISTRIBUTION
MEDICAID ELIGIBILITY FILE	States the number of Medicaid eligibles, which are broken down into category & program status.	Monthly by County & Numerical	1970 - Present	Internal	H.S. & E.& Surveillan
MEDICAID ELIGIBILITY FILE (NEWBORNS)	Listing of Medicaid eligibles born after January 1, 1970		January 5, 1974	Internal	H.S. & E.
MEDICAID ELIGIBILITY QUALITY CONTROL SAMPLE ACTIVITY			1970 - 1973	Internal	H.S. & E.
MEDICAID PROCEDURES-PHYSICIANS	Reimbursement for physician services by area, specialist & non-specialist.		12/21/70	Internal	H.S. & E.
MEDICAID STATUS FILE	ADC only	Quarterly listing		Blue Cross	Surveillance

INVENTORY OF COMPUTER PRINTOUTS

REPORT NAME	PURPOSE OF REPORT	FREQUENCY & SEQUENCE	DATES AVAILABLE	SOURCE	DISTRIBUTION
MEDICAL ASST. PAYMENTS BY PROVIDERS	A summary of payments by type of service & category of eligibility of the recipients.	Monthly by county	1970 - Present	Blue Cross & Prudential	H.S. & E. & Surveillance
MEDICAL ASST. PAYMENTS BY TYPE OF SERVICE	States payments for contractors & for nursing homes	Monthly by county	1970 - Present	Internal	H.S. & E.
NATIONAL DRUG CODE LISTING	Lists nation drug code, reporting unit, product description & pkg. size, manufacturer & unit price	Alphabetical listing	3/30/70	Blue Cross	H.S. & E.
PER DIEM RATES	Listing of authorized per diem rates for hospitals, home health agencies, & clinics		1970 - Present	Blue Cross	H.S. & E., & Claims & Accounts
PERSON COUNTS OF RECIPIENTS BY TYPE OF SERVICE & BASIS OF ELIGIBILITY	States recipients & their basis for eligibility	Quarterly by county	1972 - Present	Internal	H.S. & E.
PROCEDURE TABLE	Codes				Surveillance

INVENTORY OF COMPUTER PRINTOUTS

REPORT NAME	PURPOSE OF REPORT	FREQUENCY & SEQUENCE	DATES AVAILABLE	SOURCE	DISTRIBUTION
PROVIDER LISTING (ALL OTHER)	Reference	Numerical by Provider	1970 & 1971 Upon request	Prudential	Surveillance
PROVIDER LISTING (PHYSICIAN)	Reference	Numerical listing	1970 & 1971	Prudential	Surveillance
PROVIDER UTILIZATION SUMMARY REPORT	Measuring claim activity by provider according to claims & visits or days.	Monthly by county Also Semiannually & Year-to-date	1970 - Present	Internal	H.S. & E., Surveillance Claims & Accounts
PRUDENTIAL CLAIMS		Monthly listing (Microfilm)		Prudential	Surveillance, & H.S. & E.
RECIPIENT (BENEFIT TYPE) UTILIZATION SUMMARY REPORT	Each benefit type is broken down into eligibility categories.	Monthly by benefit type	1970 - Present	Internal	H.S. & E.
RECIPIENT (COUNTY) UTILIZATION SUMMARY REPORT	States payments, cases eligible and cost per eligible within county basis	Monthly by county	1970 - Present	Internal	H.S. & E. & Surveillance

INVENTORY OF COMPUTER PRINTOUTS

REPORT NAME	PURPOSE OF REPORT	FREQUENCY & SEQUENCE	DATES AVAILABLE	SOURCE	DISTRIBUTION
RECIPIENT SURVEILLANCE REPORT	Recipients over established criteria flagged	Monthly by county Also semiannually & Year-to-date	1970 - Present	Internal	H.S. & E. & Surveillance
RUTGERS REHABILATION EXPANSION GRANT	Referrals & disposition of cases. Quarterly, demographic data on case load	Monthly listing	July 1972 - Present	Rutgers University	H.S. & E.
SPECIAL FLAG DRUGS			Nov., Sept., Aug., July, June, May, & April 1970	Internal	H.S. & E.
SPECIALTY CODE PROVIDER LISTING	Annual run of Prudential providers listed within specialty code.	Annual listing	1970 - Present	Prudential	H.S. & E.
STATISTIAL REPORT ON NUMBERS OF RECIPIENTS & AMTS. OF ASST. UNDER P.A. PROGRAM	Shows payments - adult, child & total recipient	Monthly by county		Internal	H.S. & E.
SUMMARY OF ERRORS AGED BY COUNT	Corrects errors on MAP file forms	Weekly listing	Dec. 1970 - Present	Blue Cross	H.S. & E.

INVENTORY OF COMPUTER PRINTOUTS

REPORT NAME	PURPOSE OF REPORT	FREQUENCY & SEQUENCE	DATES AVAILABLE	SOURCE	DISTRIBUTION
SURVEILLANCE REPORT	Providers exceeding established criteria are flagged	Monthly report	1970 - Present	Internal	H.S. & E., Dr. Hood Dr. Erlichman, Dr. Greenfield, Dr. Senaldi, Dr. Gol Mr. Gaynor, Mrs. Han & Surveillance.
SYSTEM CONTROL SUMMARY REPORT	Nursing Home payments by level of care: skilled NH, ICF level A & B, for all recipients & MAA & CR recipients		1970 - Present	Internal	H.S. & E. & Claims & Accounts
VISITS DISTRIBUTION	Number of visits by provider number		March-Dec. 1970	Internal	H.S. & E.
WORKLOAD REPORTS	Listing of claims received, paid, returned, processed, pending by type of service	Monthly by type of service	1970 - Present	Blue Cross & Prudential	H.S. & E.

APPENDIX D

PROCEDURE

FD-38C1 - Complaint Intake and Summary Form

The Complaint Intake Form FD-38 C1 will be the prime document for recording intake and disposition of each complaint, so that when disposition has been achieved, the original complaint and its disposition will be recorded on the same sheet.

Recording

1. All complaints, regardless of source are to be recorded in triplicate on the Complaint Intake and Report Form (FD-38 C1).

2. It is not expected that the FD-38 will be typed.

3. The FD-38 C1 (Complaint Intake and Report Form)

    1. Enter your name, title and date, as the person receiving complaint.
    2. Enter the recipients name, address, telephone number, and HSP number if applicable.
    3. Fill in the complainants relation to the Program or recipient.
    4. Fill in the complainants name, address and telephone number.
    5. Enter the subject of the complaint.
    6. The providers name, address and County.
    7. Summary of Complaint:

        Include all information, extracted from complaint as to who, what, when, where, how, and how many times. When complaint is submitted in writing, attach all original letters, documents and other written material to the original FD-38 C1 form.

    8. Enter notations of referrals, dates, actions, disposition and recommendations, if any, should be complete to the extent possible, in the spaces indicated. NOTE: If required to make referents report clear, concise, correct and complete, actions can be documented on a separate sheet marked Original Report which is attached to original FD-38.

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

_____
DATE

COMPLAINT INTAKE & REPORT

COMPLAINANT: PROVIDER _____
RECIPIENT _____
STAFF _____
OTHER (SPECIFY) _____

_____
NAME INTAKE

_____
TITLE

SUBJECT: (SERVICE) _____

_____
PROVIDER NAME

_____
RECIPIENT NAME HSP #

_____
ADDRESS

_____
ADDRESS

_____
CITY COUNTY

_____
PHONE, IF ANY

****

SUMMARY OF COMPLAINT
(USE REVERSE SIDE, IF NEEDED)

****

REFERRED TO: (NAME & TITLE) DATE ACTIONS

RECOMMENDATIONS

FINAL DISPOSITION

FD-38 C-1 10/74

Your complaint of _____ against the _____
Date Nursing Home

concerning _____ was received today.
Nature of complaint

Please be assured that we will make every effort to investigate and review your complaint and take whatever corrective action may be necessary.

Thank you for taking the time to inform this office about the problem.

Very truly yours,

LONG TERM CARE COMPLAINT REPORTING SYSTEM

PURPOSE

The formal reporting of complaints and problems serves the purpose of growth and development of the Program and its Staff.

The Director must have information concerning the Program operations in order that existing policy and procedures be viable and productive. When information indicates the contrary, executive administration can direct changes to assure proper development of the Program.

The Chief, Medical Care Administration must be provided with long term care dossiers on complaints for developing a profile and determining any trend which may exist concerning a particular facility and in instances where the review and evaluation indicates that a significant or serious situation exists which is detrimental to the health, welfare and safety of Medicaid patients to initiate necessary action.

Supervisory and management personnel will be provided with a tool for keeping them knowledgeable of problems for which they would be taking corrective action and supervisory monitoring in developing Program staff to the extent of their capability.

DEFINITION

For purposes of clarification, a complaint is considered to be a problem, observation, resentment, an allegation or any expression of dissatisfaction received by this Division from the staff or from any outside source which is considered to be a variance with standard or customary practices by the complainant and which unless satisfactorily resolved could exert a detrimental effect on a recipient, provider, facility and/or the Health Services Program.

Complaints may be generated from multiple sources, e.g., staff evaluation, reports from the general public by letter or telephone, patients, patients relatives, facility employees and referrals from other agencies, etc.

GENERAL POLICY

All complaints must be answered promptly acknowledging receipt and that the complaint will receive appropriate action (model attached). This will be the responsibility of the addressee or if addressed generally by the Local Administrator if received at the local level, by the Complaint Coordinator if received at the Central Office.

Action relative to all complaints will be carried out to the extent possible by the Local Medical Assistance Units.

The Complaint Intake Form FD-38 will be the prime document for recording the intake, referral and disposition so that when disposition has been achieved, the original complaint and its disposition will be recorded on the same sheet.

The person who actually receives the complaint or observes the condition in the long term care facility is responsible for filling in the FD-38 in triplicate..

The source of all complaints is to be kept confidential and may be cause for disciplinary action if any staff member, for any reason reveals a source to anyone other than to appropriate authorities. However, the name of the complainant may be divulged with the complainant's permission.

COMPLAINTS RECEIVED LOCALLY

The Administrator in the Local Medical Assistance Unit is the position to which all complaints from the community and staff, including referrals from the Complaint Coordinator will be reported since this is the single position which is present at all times in the Unit and is knowledgeable of Division policies relative to all Medicaid covered benefits.

The Administrator refers the complaint on an original FD-38 to the proper discipline(s) for action and retains a copy of the FD-38 in the pending file at the LMAU.

The complaint now becomes a Unit responsibility in the LMAU and all disciplines of the LMAU will be made aware of any problem and its ultimate resolution.

Complaints relative to the payment process would not be included in the team review but would be handled by the Local Administrator to the extent possible, whether the complaints are from recipients about facility billings or complaints from long term care facilities about their billing problems.

The Administrator of the LMAU assumes the singular responsibility, as the person who achieved the disposition of all complaints, received at or referred to the LMAU, of informing the complainant of the fact and substance of the disposition.

Complaints, satisfactorily resolved at the LMAU are forwarded on the original FD-38 (with "sign off" by staff involved in the disposition) to the Complaint Coordinator with the original letter of complaint, if any, and a copy of the notice of resolution to the complainant. The reports must include a recommendation and/or a judgment as to whether the investigation confirmed or did not confirm the complaint; a copy of the report is retained at the local unit.

Example 1: The Regional Staff Nurse reports to the Administrator (on FD-38 in triplicate) that an attending physician has not kept his progress notes current on skilled nursing home patients. The Administrator refers this (on original FD-38) to the Local Medical Consultant, who secures the attending physician's obligation for compliance, reports this to the Local Administrator (on FD-38). The Administrator, assuming responsibility for the disposition of the complaint, acquaints the complainant (Regional Staff Nurse) with the resolution, requests tickler for 30 days, and forwards the original FD-38 (with team"sign off") to the Complaint Coordinator with a copy of the notice of resolution to the RSN, a copy is retained at the LMAU.

LOCAL COMPLAINT UNRESOLVED

If it is the collective judgment of the Local Unit that a complaint may be too complex in nature, requre higher authority for resolution, that complaint in its original form, shall be forwarded by the Local Administrator to the Complaint Coordinator. The complaint is now considered to be central in nature and will follow the same format, noted below, that any complaint would follow if it had been received at the Central Office originally, instead of at the local level.

COMPLAINTS - CENTRAL OFFICE

The office of Medical Care Administration functions as the central point in the Division for receipt of all complaints concerning long term care facilities.

The Complaint Coordinator in the Central Office has the responsibility for assuring that:

All complaints received at the Central Office, including those that were not resolved at the LMAU, will be answered promptly acknowledging their receipt and that the complaint will receive appropriate action.

Complaints, applicable to action by the LMAU staff are directed to the appropriate Administrator of the Local Medical Assistance Unit (on an original FD-38) with a copy of the written complaint, if any; a copy of the FD-38 with the original complaint will be retained in the pending file in the Central Office.

Complaints received in the Central Office including unresolved complaints referred by Local Units which are complex in nature, require higher authority for resolution or are of serious enough nature to be detrimental to the health, safety or welfare of Medicaid patients will be referred to the Chief, Medical Care Administration for recommendations for referral or advice on handling.

Reports on the review and investigation by the Local Medical Assistance Units will be forwarded to the Division of Health Facilities, State Department of Health for review and action.

The person referring a complaint to the Central Office, or referring a complaint in a Local Unit, which cannot be resolved at that level, will be advised by the Complaint Coordinator of the fact and substance of the disposition.

The Bureau of Long Term Care will be alerted to all follow-up complaint investigation reports received from the State Department of Health.

The Local Medical Assistance Units will be informed of the nature of resolution of complaints originally received in the LMAU but unable to be resolved at that level and referred to the Complaint Coordinator.

A central file dossier on complaints for each long term care facility will be maintained.

A current overall record of long term complaints, referrals and disposition will be maintained.

A regular monthly report of statistics, nature of complaints, referrals, disposition and other essential information will be submitted to the Chief, Medical Care Administration.

Final filing of all resolved complaints will be maintained in Central Files, both as individual complaints and as compilation data.

KTC:fb

DEPARTMENT OF INSTITUTIONS AND AGENCIES

INTER - OFFICE COMMUNICATION

Through: Alan G. Wheeler, Assistant Chief
Medical Care Administrator

Date: June 5, 1975

To: Gerald J. Reilly, Director
Division of Medical Assistance & Health Services

From: Doris B. White
Complaint Coordinator

Subject: Complaint Summary Report - May, 1975

NURSING FACILITY COMPLAINTS

Statistics: This month 31 new complaints were received against 23 nursing facilities representing more than a 40% increase in complaints over last month. Of these, 13 originated with patients or their relatives, with two of these referred from other agencies, 15 came from the staff, one came from a volunteer and one from the Bureau of Local Operations. In addition, three follow-up reports were received of previously reported complaints.

Of new complaints to date, four could not be substantiated, six were satisfactorily resolved, two were unsatisfactorily resolved (one involved representative payees and the other, a request for transfer followed by patient's death), two were referred for audit, nine were referred to the Department of Health and the remainder were pending follow-up review.

Department of Health Referrals

The nine new complaints referred to the NJSDH included the following: [redacted] Nursing Home, roaches (staff); two against [redacted] Convalescent Center, patient treatment, fall (relatives); two against [redacted] Nursing Home, prescribed therapy not carried out, use of staff (staff); two against [redacted] Nursing Home, patient care (staff) and [redacted] Hospital, inadequate staffing (staff).

During May, the NJSDH returned follow-up reports of complaints against [redacted] ICF (4/1/75) and [redacted] (2/28/75). Both involved patient care and NJSDH found complaints unsubstantiated.

To date, ten referrals prior to this reporting period remain pending follow-up reports. The questions of whether NJSDH follow-up reports should be the final word or whether these reports should undergo critical review have been raised by staff, and to date have not been resolved.

Unusual Complaints

Possibly as a result of widespread publicity, during the month the Complaint Coordinator received three complaints against [redacted] Convalescent Center as

well as one against [redacted]. All but one were initiated by relatives of patients, and all centered on multiple issues, mainly patient care and handling of personal incidental monies. Currently pending investigation is a complaint of patient abuse at [redacted].

Four complaints against [redacted] SNF came from staff indicating that in at least two instances prescribed physical therapy was not being carried out, and two other complaints indicating inappropriate use of facility staff. All of these were referred to NJSDH, as non-compliance issues, and the former two complaints are being followed through by the medical consultant.

This Division continues to receive complaints from families of patients seeking return of deposits required of them as a condition for admission, prior to establishment of Medicaid eligibility, in addition to ongoing complaints about the handling of personal monies.

In addition, two complaints respectively by staff and a patient's relative against [redacted] Nursing Home give evidence of poor quality of patient care. These were also forwarded to NJSDH.

HOSPITAL COMPLAINTS

This month two hospital complaints were received from staff against [redacted] Hospital and [redacted] Hospital. Both involved problems of transfer records for nursing home patients. This continues to be an ongoing complaint that should be and frequently is resolved administratively at the local level.

RECIPIENT COMPLAINTS

During May, four complaints were forwarded from recipients against providers concerning allegations (2) of extra charges to the patients. In one case, as a result of LMAU intervention, money was refunded; in the other, efforts to verify were stymied by failure of both complainant and the provider to respond to requests for information. Efforts are continuing at the local level to resolve this matter. One complaint forwarded to the Vision Care Unit centered on quality of services and the fourth recipient alleged Medicaid discrimination by a dentist. This was forwarded to the Regional Dental Consultant for resolution.

GENERAL COMPLAINTS

Staff Reports: Progress is reported with improved reporting by the Vision Care Unit and a reduction in podiatry complaints. The Dental Section has not submitted any complaint reports to date despite reminders, nor has Medical Component (except for individual nursing facility complaints).

Podiatry Unit: One complaint was forwarded by the Podiatry Consultant relative to provider dissatisfaction with fees resulting in a voluntary withdrawal from the Program. Improvement in provider relations was reported. (See Contractors' Complaint Reports)

Vision Care Unit: The Unit this month reports a total of 61 complaints this month from 25 optometrists, 17 opticians, 8 ophthalmologists and 11 recipients. In addition to previously reported areas of complaint, there were this month 15 complaints by providers indicating failure of clients to pick up glasses. Providers (12) continued to complain about certain procedures because of their failure to read the Vision Care Services Manual.

Pharmacy Unit: This month 642 complaints were received from 79 pharmacies, 11 medical supply and equipment dealers, 4 hearing aid dealers, 35 physicians and 10 others. This represents a small (5) increase over last month's total. The greatest volume of complaints centering of fees and representing about a third of the total came from pharmacies. The next highest area of pharmacy complaints was "delayed payment," with "eligibility" next. (Blue Cross' report on pharmacy claims complaints does not conform to this pattern, as noted below)

Contractors' Complaint Reports

Effort was made this month to receive clarification and definition of Blue Cross' "delayed payment" complaint category, as this has continued to represent the largest complaint area, particularly for hospitals. Blue Cross' report included such an explanation, noting that whenever a provider has not received payment within 30 days, a follow-up notice is sent to Blue Cross. Each such notice is regarded as a "delayed payment" complaint, even though in many cases claims were either previously declined, processed for payment or returned for additional information. Blue Cross indicates that efforts are being made through the Provider Relations Department to overcome these kinds of billing problems. In the meantime, it would appear that the "delayed payment" category, as reported, is somewhat distorted and does not actually reflect what is implied.

This month Blue Cross reports a total of 5,156 pharmacy complaints from 602 providers, representing more than a 50% increase, due mainly to inclusion of 2,257 in the "other" complaint category, which includes policy questions, queries on late or missing checks, and requests for forms. Eligibility with 962 complaints and fees with 893 are the pharmacists' major areas of complaint this month.

Hospital complaints decreased this month by 464, with a total of 757 from 102 providers. "Delayed payment" continued to constitute more than 90% of all hospital complaints.

In addition, Blue Cross reports nine fair hearings and 56 recipient complaints related to incorrect SSI information.

For the reporting period, Prudential reported a decrease of 959 complaints under last month's total, with 8,442 complaints reported from 3,954 providers. Two significant decreases appeared in this month's report: vision care provider complaints were reduced by 479 for a total of 591; and podiatry complaints were reduced by 115 for a total of 82 this month. Physicians (2,260) and dentists (444) were accountable for most of the complaints with fees and delayed payment the major areas of complaint for virtually all provider groups.

DBW:fb

APPENDIX E

Division of Medical Assistance and Health Services
Bureau of Local Administration
Monthly Statistical Summary Report

Jerome F. Murphy
Chief, Bureau of Local Administration

Nov. 15 to December 14, 1975

Services	Pending Beginning of Period	Total Intake	Total Processed: Approved	Total Processed: Denied	Pending End of Period	COMMENTS
Pharmaceutical	—	299	284	15	—	
Medical Supplies & Equipment	16	858	848	22	14	
Hearing Aids	11	132	136	2	5	
Hearing Aid Accessories & Repairs	1	151	149	1	2	
Physical Therapy	15	524	487	47	5	
Speech & Hearing Therapy	4	160	154	8	2	
Occupational Therapy	—	61	59	2	—	
Prosthetic & Orthotic	4	225	222	6	1	
Orthopedic Shoes	14	870	759	106	19	
Home Health	3	487	489	—	1	
Dental	875	7912	6180	1639	760	268 returned for correction
Ambulance	33	518	550	3	28	
Invalid Coach	5	2363	2251	12	5	
Notices of Hospital Admissions		9217				
Others (Specify)						
SPECIAL HOSPITALS	—	29	29	—	—	
FOOD SUPPLEMENTS		4	4	—	—	

	Patients Conferences	Patients Authorized	Patients Denied	Case W'ker Attendance	Transfers
Long Term Care	3615	3558	57	505	52

		Total	MC-1C	MC-15	LTC Conference	Other Auth. Requests
Rehabilitation Referrals	This Month	—	—	—	—	—

	Total Referred	Total Accepted	Total Rejected	Total Terminated	Total Unknown
To Date	110	26	29	10	54

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